MOTHER'S MILK AND MOTHER'S TEARS:

BREASTFEEDING EXPERIENCES IN MOTHERS WITH POSTPARTUM DEPRESSION

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By

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ABSTRACT

With an increasing amount of attention being paid to maternal mental health and the knowledge that maternal depression has the potential to adversely affect the breastfeeding relationship, the demand for appropriate breastfeeding support for mothers struggling with postpartum depression is on the rise. Using a hermeneutic phenomenological approach, the objective of this thesis research was to explore the lived experience of breastfeeding in women with postpartum depression to enhance understanding of what it means for these women to feel supported by registered nurses.

After obtaining ethical and operational approval, recruitment began in September 2011 via the Saskatoon Postpartum Depression Support Program, a community wellness program offered by the Saskatoon Health Region. The researcher conducted in-depth, conversation-style interviews with five postpartum mothers. Interviews were transcribed verbatim and were analyzed according to emerging themes.

The lived experience of breastfeeding with postpartum depression presented itself across interviews as overarching patterns, which are expressed by the following four themes: *making the decision to breastfeed and having great expectations; learning the moves and wanting reassurance (establishing the breastfeeding relationship); breastfeeding in the dark (maintaining the breastfeeding relationship while trying to manage the symptoms of depression); keeping it under wraps and waiting it out (the issue of support).*

The mothers in this study valued the breastfeeding relationship when it went well; however, breastfeeding difficulties intensified symptoms of depression. Mothers who made the decision to breastfeed their infants needed ongoing support from healthcare professionals and loved ones to continue to breastfeed when faced with the debilitating symptoms of postpartum depression.

This research concluded that women need increased anticipatory guidance to be prepared for the demands of motherhood. Women who are at risk for postpartum depression need appropriate treatment throughout the perinatal period and beyond. To these ends nurses must enhance their role as breastfeeding and postpartum depression educators across an extended perinatal period. Nurses should work along with other healthcare providers (midwives, social workers, physicians) to assess the effectiveness and appropriateness of prenatal classes as they are currently offered. Increased emphasis should be focused on newborn feeding and care for mother and baby postnatally in conjunction with prenatal preparation for birth itself.

The issue of professional nursing support for breastfeeding must be explored from a sociopolitical context in order to determine if nurses have the cultural and institutional support they need to provide responsive care to mothers and babies. Enhanced support for breastfeeding certification among frontline staff is recommended. It is also recommended that staffing guidelines to decrease nurse-to-client ratios be implemented in order to give nurses the time needed to support mothers as they work through breastfeeding challenges (especially those mothers at risk for postpartum depression). Further, nurses need to enhance efforts to engage mothers and their families in a participatory manner so that knowledge gleaned results in responsive interventions.

DEDICATION

For my mother, Wendy. Thank you, Mom, for your years of devotion: Your enthusiasm for maternal child nursing is my inspiration; your unconditional love is my strength.

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My heartfelt thanks goes out to the mothers who participated in this study. It is my sincere hope that they have found some relief from the strangleholds of depression since we first spoke. Appreciation is also extended to the facilitators of the Postpartum Depression Support Program, Saskatoon Health Region. Several people and funding agencies also deserve a special thank you for their contribution to the completion of this thesis. First, I would like to acknowledge the financial support I received through a research grant from the Canadian Association of Perinatal and Women's Health Nurses. In addition, a Masters Award from the Canadian Institutes of Health Research and funding as provided by the Muriel E. Kavanagh Memorial Fund and the Alice Caplin Nursing Fund supported my studies and allowed me to concentrate on completing this research in a timely manner, and to be a mother at the same time.

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To my husband, Seth, and our baby, Nathaniel: Thank you for your patience and for always reminding me that there is nothing better than a "family hug."

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INTRODUCTION AND OVERVIEW

This thesis is presented in manuscript format as partial fulfillment of the requirements for the Degree of Masters of Nursing from the University of Saskatchewan. The aim of the research was to explore the lived experience of breastfeeding in mothers with postpartum depression, and to come to a clearer understanding of what it means for these women to feel supported to breastfeed by registered nurses. This inquiry used a phenomenological perspective to explore mothers' lived experiences of breastfeeding and followed a hermeneutic process of data analysis as a means to articulate their stories and elucidate the support phenomenon. It is hoped that the findings from this work will enhance understanding of mothers' experiences of breastfeeding with postpartum depression and that it will inspire both practical implications for nursing support and continued research in the realm of maternal child and maternal mental health.

The Phenomenon of Interest

The necessity to elucidate the concept of breastfeeding support is both global and local as infants continue to suffer consequences related to a lack of breastfeeding and/or short breastfeeding duration (McNiel, Labbok, & Abrahams, 2010; U.S. Department of Health and Human Services, 2011). In fact, it is estimated that "If 90% of US families could comply with medical recommendations to breastfeed exclusively for 6 months, the United States would save $13 billion per year and prevent an excess 911 deaths" (Bartick & Reinhold, 2010). In addition, with an increasing amount of international attention being paid to maternal mental health and the knowledge that maternal depression has the potential to adversely affect the breastfeeding relationship, the demand for appropriate breastfeeding support for mothers struggling with postpartum depression is on the rise (Dennis & McQueen, 2009; Nishioka et al., 2011). Attempts to explore women's satisfaction with support interventions for breastfeeding have not yet filled

the research void (Britton, McCormick, Renfrew, Wade, & King, 2007). As such, the aim of the present research is to increase understanding of the experience of breastfeeding in women with postpartum depression and to illuminate the concept of support for breastfeeding within that experience.

Justification for the use of Phenomenology

Situated in the realm of human science. Graduate studies have helped me to acknowledge the expansive nature of nursing science and the fact that data from both quantitative and qualitative methods has value. Nursing science recognizes knowledge gleaned from a full continuum of paradigmatic thought (Barrett, 2002). Whether the setting is clinical or research-based, nurses gather relevant nursing data to build a knowledge base, interpret the data collected, and have available nursing theories to guide action thanks to generations of theorists from Nightingale to Watson. Thus, the nursing profession finds its vigour in nurse/researcher and client/participant encounters that strive for wholeness, integrity, authenticity, and acceptance of context as relevant to the time (Reed & Crawford Shearer, 2009).

In their momentous contribution to nursing literature, "The Focus of the Discipline of Nursing," Newman, Sime, and Corcoran-Perry (1991) offered: "Nursing is the study of *caring in the human health experience*" (p. 3). Based on this focus, the authors added that nursing knowledge depends on the perspective of the scientist (p. 5). In 2008, Newman, Smith, Dexheimer Pharris, and Jones revisited the focus of the discipline and furthered their vision to allow for the possibility that nursing knowledge might even transcend the limitations of paradigms. Distinct from the strongholds of a traditional scientific approach, they describe nursing knowledge as all knowledge gleaned from caring relationships in which the nurse is fully present and "focused on the meaning of the current situation" (p. E17). In addition, they offer,

"Nursing knowledge unfolds within a participatory process" (p. E17). I assert that this statement speaks to the nature of nursing knowledge as situated in the realm of human science and I agree with Cody and Mitchell (2002) who recognize that nursing is "a field in which the context for all work is unbounded human diversity" (p. 7):

> Human science nursing means learning how to care for people in a context in which the primary value is honoring and upholding individuals' and groups' rights to think, feel, and act out of their own lived experiences in relation to health and quality of life. (Cody & Mitchell, 2002, p. 8)

If we concede to the idea that the nature of nursing knowledge exists in the sphere of human science, then we may accept that nursing research values human lived experience in all of its inexplicable glory. Cody and Mitchell (2002) describe this postmodern perspective as one that "holds as *real* and *deeply values* love, courage, altruism, art, ethics, grace, friendship, and play" (p. 11)—dimensions of human life that are difficult to explain using scientific realism.

The influence of hermeneutics. Intrigued by the philosophy of human science, I pursued my thesis proposal surrounding issues of infant feeding and postpartum depression and began to explore the many varieties of qualitative research classified under the auspices of phenomenology. Hermeneutic, or interpretive, phenomenology as inspired by the work of van Manen (1990) was used as inspiration for the present study. While a more in-depth presentation of hermeneutic phenomenology is included in the Proposal section of this thesis, at this point it is sufficient to introduce van Manen's hermeneutic phenomenology as both philosophic perspective and mode of inquiry: "the act of researching—questioning—theorizing is the intentional act of attaching ourselves to the world," such that research becomes "a caring act" to serve and to share our being with another (1990, p. 5). To this end, there is a focus on researcher and participant relationships and on a process of inquiry whereby data is "made rather than merely *collected*" (Richards & Morse, 2007, p. 107).

It might also be argued that, given the aim of this research (to delve into the sensitive nature of postpartum depression and infant feeding decisions), the subject matter necessitated the use of hermeneutic phenomenology: the methodology for such research would need to be flexible in order to fully appreciate and adapt to the unique perspectives of the women interviewed. Fortunately, van Manen's (1990) approach embraces the exploration of procedures and sources that are not always foreseeable at the outset of a research project. Munhall (2007) refers to this notion of flexibility, particularly with regard to one's capacity to incorporate emergent themes, as the ability "to follow *the thing itself* wherever and whenever it appears, while being attentive, conscious, and alert to its appearance or concealment" (p. 151). On a practical level, I did not know if women suffering with postpartum depression and experiencing the challenges of caring for a newborn would be willing, or able, to talk with me; the research methods would need to be flexible. Moreover, I would need to be responsive to the data as it unfolded because I could not anticipate what direction it might take. The only way to get a feel for the process of hermeneutic phenomenology was to begin!

Van Manen's approach: "A good fit." Early in the progression of this research, it became apparent that van Manen's (1990) approach would also accommodate another challenge: given the multifaceted nature of breastfeeding with postpartum depression, capturing a "universal essence" of the phenomenon might be virtually impossible. Finlay (2009), in her ample review of the many variants of phenomenology, explains that van Manen's methodological structure, as distinct from more traditional phenomenologies (which seek to offer general insights of a phenomenon or to explain a phenomenon as a whole), emphasizes an exploration of experience as it is *lived*, respecting notions of subjectivity, perspective, and reflection. For van Manen, this search for "lived meaning" necessarily implies a description of

"those aspects of a situation as experienced by the person in it" (p. 183). Further, *hermeneutics* denotes the search for meaning and understanding through interpretation such that "there are no such things as uninterrupted phenomena" (p. 180). Data gleaned regarding the experience of breastfeeding with postpartum depression would be an inevitable consequence of interpretation: from the mothers' memory and re-telling of their experience, to my search for meaning in their words, and to the final representation of that meaning thematically.

Reflexivity: Circular and iterative. A final advantage inherent in using van Manen's approach, is that it allows for a description of the researcher's own lived experience and self-reflection with regard to the phenomenon of interest. Van Manen (1990) suggests that this reflective process allows researchers to orient themselves to the phenomenon and to acknowledge personal experience as an important source of human science data. Thus, rather than needing to shroud or "bracket" out my own experiences as a mother and postpartum nurse (bracketing being a technique of more traditional phenomenological methods [Dowling 2007; Finlay, 2009]), these insights would offer not only an important starting point for the research, but an important source for reflection throughout the research process. With regard to the degree with which researcher subjectivity is used in phenomenological research, Finlay (2009) offers: "The researcher engages a dialectic movement between bracketing preunderstandings and exploiting them reflexively as a source of insight" (p. 13). In this context, researcher reflexivity becomes a "process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings" (Finlay, 2003, p. 108).

Thus, I approached the present research inspired by the possibilities inherent in van Manen's perspective and I realized that while it would be impossible to completely deny my own

perspective, I would need to approach the phenomenon of breastfeeding with postpartum depression from a perspective of "unknowing." Based on the writings of Munhall (2007), phenomenological inquiry adopts a perspective of unknowing as "a condition of openness" (p. 76), where "unknowing is an art…essential to the understanding of intersubjectivity and perspectivity" (p. 172). I needed to acknowledge all that I did *not know* about breastfeeding, postpartum depression, and the profession of nursing before I would be able fully appreciate the implications of mothers' words. My intent was to listen to the women, and to honour their voices.

The next section of this thesis offers an experiential account of my own postpartum experience (both as mother and nurse), which has led to the present inquiry. It is presented as a methodological component of van Manen's (1990) hermeneutic phenomenology: "turning to a phenomenon that seriously interests us and commits us to the world" (p. 30).

EXPLICATING ASSUMPTIONS AND PRE-UNDERSTANDINGS

I had heard that having a baby would feel like "love at first sight," so when my son was born, I felt disappointed that I did not have that feeling right away. I remember being alone with my son for the first time in the hospital. My husband needed to be at work and my own mother was making arrangements to be with us as soon as she could. The nurse would come into my room and remind me that it was time to feed my baby: I sat and wept. I didn't know what to do, or if I did, I didn't trust that I knew. Holding the tiny baby, let alone feeding him at my breast, felt so uncomfortable. What if he wasn't getting enough milk? I was afraid to ask the nurses for help … surely, I should know how to care for my own baby.

My mother soon arrived, and life seemed manageable with her by my side. I was surprised that breastfeeding did not seem to come naturally and that my baby and I both needed to learn techniques. My mom helped me to find comfortable positions to nurse in, and even woke with me in the night for every feed. But when it was time for my mom to go back to her world, my own felt turned upside down. I became increasingly anxious and exhausted. It got to the point that when baby would cry for hours on end, I would cry with him and the best I could do was hope that *our* next nap might be longer. At six months postpartum—or maybe it was closer to nine months—with considerable support from my husband and our family, we finally began to find our rhythm together as mother and son.

Two years later, I started the Nursing Education Program at the University of Saskatchewan and was compelled to focus my studies in the area of maternal child nursing. Fresh out of undergraduate school, I began my humble practice working on the postpartum unit at the Royal University Hospital in Saskatoon, Saskatchewan. I was determined that no mother assigned to my care should be left feeling neglected. What I soon realized was that my own postpartum experience paled in comparison to the circumstances most new mothers must face. Many new mothers undergo emergent cesarean sections or any one of a number of other obstetrical complications. Some are diabetic, some hypertensive, others are addicted, or obese, or physically or emotionally abused. Some struggle with psychological and/or emotional disorders. Some new mothers live in poverty. Some are newly immigrated to Canada, speak not a word of English, and have no friends or family in this country. Some have no “support” person at all. There are mothers whose babies are whisked away to the Neonatal Intensive Care Unit, and mothers who must return to their homes hundreds of kilometres from babies who remain in intensive care. Some mothers have their babies apprehended by Social Services without a

moment's warning. Adding insult to injury is that all of these situations occur in the unfamiliar surroundings of a hospital, where rooms may be shared with up to two other families and care is dependent on a nurse who is often scrambling to complete an ever-growing list of requisite tasks.

Five moms and their babies are routinely assigned to each registered nurse on the postpartum unit, despite practice guidelines that recommend one registered nurse to four healthy mother/baby dyads (Health Canada, 2000). It is also not unusual that a nurse may discharge up to three or four families and admit just as many new families on a single shift. Being relatively new to the system, I felt overwhelmed by the patient load and burdened by a lack of experience. While each shift provided the practice of managing situations ranging from child apprehension, to substance abuse and medical emergencies such as hemorrhage, it was a rare occasion that I would have time to provide what I believed was adequate support for mothers wishing to breastfeed.

Much to my dismay, finding mothers in tears was commonplace. At the same time, I became aware that I was not the only nurse struggling with inadequate time to provide quality care and that there was a growing culture among nurses to count one's blessings if you were assigned a mother who had already made the decision to feed her baby using artificial baby milk. One nurse scolded me at shift change, "If God had wanted all babies to breastfeed he would have made all nipples the same." And another nurse: "This breastfeeding business will go out of fashion again. There's a new article out that says that breastfeeding isn't all that it's made out to be."

One morning I found a mother crying. She explained that the night nurse had taken her baby out of the room so that she could sleep. "The nurse said she would *finger feed* my baby; but I didn't understand that meant she would give my baby formula." The young mother explained

that she thought the nurse would just soothe her baby with her finger. Soon, I found myself wanting to warn women that artificial baby milk was often offered in hospital as a quick and dirty solution to the challenges of supporting breastfeeding. I wanted to encourage women to go home at the earliest possible time in the hope that they might receive enhanced care from nurses and lactation consultants working with the early discharge program in their own homes.

At the same time, there seemed to be a growing disquiet among some of my nursing colleagues, some physicians, and in social media circles, that breastfeeding was an unnecessary burden for women to have to endure. Public and professional resistance to breastfeeding protection, promotion, and support was being expressed as a concern about unwelcome pressure on mothers to breastfeed when they are not so inclined. Most recently, this opinion was stated publicly by Joan Wolf, women and gender studies professor from Texas A&M University, in the January 2011 edition of MacLean's magazine (Savage, 2011). As a new nurse, I felt confused and unsure. I believed that ensuring informed consent before handing out artificial baby milk was necessary. Given that the deleterious effects of manufactured baby milks on infant health and survival are well documented (American Academy of Pediatrics, 2012; McNiel et al., 2010; U.S. Department of Health and Human Services, 2011); not to inform families would be negligent, would it not? Yet, there also seemed to be an unspoken belief among my colleagues that to inform families of the risks of formula feeding would be to induce needless stress and guilt. It appeared to me that the work of providing “support” to mothers, regardless of their infant feeding decision, was elusive despite subscribed unit “policy”: a concept left to the discretion of the nurse and most often guided by personal experience, and too often, by apathy.

This early nursing experience was enough to motivate me to tackle graduate studies in the Master of Nursing program. I wanted to delve into the literature regarding what I believed was

becoming a thorn in the practice of postpartum nursing: a lack of adequate support for women who had made the decision to breastfeed. Inspired by the research work of Dr. Angela Bowen with regard to maternal mental health, and after a practicum experience with Helen Irwin, clinical coordinator of the Saskatoon Postpartum Depression Support Program, I felt confident enough to focus my research in this area on breastfeeding women who were also struggling with symptoms of postpartum depression.

SUMMARY OF THE RESEARCH PROJECT

A hermeneutic-phenomenological design was proposed to explore breastfeeding experiences in women with postpartum depression. The research proposal, which follows, contains a review of the literature relating to breastfeeding, postpartum depression, and support as provided by registered nurses. A presentation of the research approach, as well as sampling, data collection, and analysis procedures are also included.

Data was collected over a four-month period, from September to December 2011. Five in-depth interviews were completed. Mothers were asked to describe their birthing stories, giving particular attention to the topics of infant feeding and their feelings of depression. In order to accommodate the sensitive nature of postpartum depression (PPD) and infant feeding decisions, the researcher strove for a relaxed conversational tone and dialogue as driven by the mothers themselves. Prompts included those as outlined in the Proposal Document, Appendix C. The use of an open-ended, conversation-style interview to elicit data is consistent with van Manen's (1990) hermeneutic phenomenological approach.

One change to the original proposal came about as a natural progression of the phenomenological process in that a minimal amount of data was collected through follow-up

interviews. Although all of the participants received follow-up questions via e-mail, and were also offered the opportunity to review preliminary findings, only one of the participants chose to respond to follow-up. This response was expected: it was understood at the outset of the research that the process would need to be flexible in order to accommodate the capacity of the women to participate given the debilitating nature of postpartum depression and the demands of caring for a newborn. Fortunately, all of the initial interviews turned out to be rich and explicative, and ample data was available for interpretation.

The interview guide, demographic data collection form, consent form, and transcript release are included as appendices of the Proposal. The letter of approval from the University of Saskatchewan Advisory Committee on Ethics in Behavioural Science Research, an amendment approval letter, and the letter of Operational Approval from the Saskatoon Health Region are found as appendices at the end of the entire thesis document.

Findings gleaned are presented after the Proposal in manuscript format: “Mother’s Milk and Mother’s Tears: Breastfeeding Experiences in Mothers with Postpartum Depression.” Strengths and limitations are provided, as well as general conclusions, implications for practice, and research recommendations. The thesis concludes with a general discussion and overview of the main findings of the thesis in its entirety.

RESEARCH PROPOSAL

The Benefits of Breastfeeding

The World Health Organization (WHO, 2001), Health Canada (2004), and the Canadian Paediatric Society (2005) recommend exclusive breastfeeding (no other food or drink) for the first six months of life for healthy term infants, and continued breastfeeding, with the introduction of complementary foods, for up to two years of age or beyond. Despite literature that clearly establishes that exclusive breastfeeding provides adequate nutrition and immunological benefit for infants (Ip et al., 2007), Canadian breastfeeding rates have remained relatively unchanged: The Canadian Maternity Experiences Survey, based on 2006 census data, reported that only 16.1% of Canadian infants are exclusively breastfed until six months of age (Chalmers et al., 2009). According to Statistics Canada (2011), 89.7% of women in Saskatchewan initiate breastfeeding, but only 34.3% are exclusively breastfeeding at six months. In 2005, 92% of the mothers in the Saskatoon Health Region stated that they initially breastfed their babies; yet, a recent estimate indicated that only 22% of infants are exclusively breastfed up to six months (Neudorf et al., 2009).

In Saskatoon, the consequences of low breastfeeding rates are particularly noteworthy, largely due to an increasingly diverse population and to an extreme degree of health disparity based on factors such as income and educational status. Lemstra and Neudorf (2008) reported, “The infant mortality rate in Saskatoon’s low income neighbourhoods [has been found to be] 448% higher than the rest of the city; which is worse than developing countries” (p. 1). Partyka, Whiting, Grunerud, Archibald, and Quennell (2010) added that while breastfeeding rates have increased in Saskatoon over the past few years, sustainability remains an issue. It was determined that many families “turn to infant formula within the first few months of an infant’s birth to

supplement feeding or overcome breastfeeding challenges" (p. 83). Perhaps even more significant was that focus group participants in the aforementioned study pointed to the need for more breastfeeding education and consistent support from health care professionals—namely physicians and nurses. Study participants "recalled experiences in the maternity ward...where formula feeding was introduced against the mother's wishes.... [leading] to increased difficulties during the first...months of breastfeeding and, in some cases, an increased cessation of breastfeeding by four months" (p. 83). Given the health risks to mothers and infants associated with not breastfeeding, and the fact that breastfeeding is an economically efficient and self-reliant food source, it is clear that supporting breastfeeding is a crucial primary health care strategy, one that should have much attention devoted to it.

Postpartum Depression

While there is international consensus on the benefits of breastfeeding to ensure that infants get adequate nutrition and emotional nurturing, there is also agreement on the negative impact of postpartum depression on children of depressed mothers (Murray, Woolgar, Cooper, & Hipwell, 2001; Weissman et al., 2004). According to the WHO (2008), depression is the greatest cause of disease burden in women of childbearing age worldwide. In Canada, the most recent estimate is that 3 to 20% of women experience postpartum depression during the first year after birth (Canadian Mental Health Association, 2012). Prevalence based on an average of thirteen thousand births per year in Saskatchewan means that approximately 2,600 Saskatchewan women and their families are affected by some degree of depression related to pregnancy and childbirth every year (Maternal Mental Health, 2010).

Beyond the obvious ill effects of postpartum depression on women, the effects on childhood development are also well documented, including psychological, cognitive,

attachment, growth, and developmental problems (Murray et al., 2001). Of particular concern is the impact of depressive symptoms on mothers' early interaction with their infants and the increased risk for poor infant feeding outcomes (Dennis & McQueen, 2009); mainly because early feeding is so dependent on cues given by the infant, and the mother's response to those cues. In a metasynthesis of qualitative studies exploring postpartum depression, Beck (2002) determined that mothers often express a lack of emotional connection with their infants and feel overwhelmed by the responsibilities of care giving.

The following findings from the literature are also notable: (a) Beck (1995) found that depressed mothers reported difficulty interacting with their infants, and low levels of self-efficacy; (b) Dunn, Davies, McCleary, Edwards, and Gaboury (2006) found that mothers with depressive symptomology were significantly more likely to discontinue breastfeeding than mothers who were not experiencing depressive symptomology; (c) Thome, Alder, and Ramel (2006) found that mothers who were breastfeeding exclusively had lower levels of depressive symptomology than mothers who were not breastfeeding exclusively; (d) Henderson, Evans, Straton, Priest, and Hagan (2003) found that the early discontinuation of breastfeeding was significantly associated with depressive symptomology; (e) Watkins, Meltzer-Brody, Zolnoun, and Stuebe (2011) found an association between negative early breastfeeding experiences and depressed mood at two months postpartum; (f) Dennis and McQueen (2009), in their systematic review of the literature, found only two studies (conducted by the same UK-based research team in the 1980s) showing an association between breastfeeding and increased depressive symtomology. In their final analysis, Dennis and McQueen determined that "women with depressive symptomology in the early postpartum period may be at increased risk for negative infant-feeding outcomes, including decreased breastfeeding duration, increased breastfeeding

difficulties, and decreased levels of breastfeeding self-efficacy" (p. e736). The authors suggested that if we hope to improve infant feeding outcomes among depressed mothers, we must explore what type of breastfeeding support is needed to enhance the postpartum experience for these women.

Despite the aforementioned findings, the relationship between postpartum depression and breastfeeding remains a contentious topic (Bogen, Hanusa, Moses-Kolko, & Wisner, 2010; Dennis & McQueen, 2009; McCarter-Spaulding & Horowitz, 2007). Public and professional resistance to breastfeeding protection, promotion, and support is often expressed as a concern about unwelcome pressure on mothers to breastfeed when they are not so inclined. Most recently, this opinion was stated publicly by women and gender studies professor, Joan Wolf, in the January edition of MacLean's magazine (Savage, 2011). In addition, there is a growing sentiment (even among healthcare professionals) that if mothers are depressed, breastfeeding is an unnecessary burden (McCarter-Spaulding & Horowitz, 2007)—or worse, that breastfeeding is the cause of the mother's depression and should be discontinued (Kendall-Tackett et al., 2007). Given the negative consequences of postpartum depression, it seems reasonable to wonder if the critical effects of the illness might be contributing to breastfeeding attrition; however, for health professionals to assume that mothers with depression do not want to continue, or may not be able to maintain breastfeeding, may be inaccurate (McCarter-Spaulding & Horowitz, 2007). It is hoped that the present thesis research will help us to better understand if and how breastfeeding promotion, protection, and support is implicated in the challenge of caring for postpartum women suffering with depression.

Breastfeeding and Postpartum Depression: Understanding Support

The wide spread use of *support* to describe necessary interventions in nursing practice and research is likely related to the recent emphasis in health care on principles of patient-centered, family-centered care (Stoltz, Anderson, & Willman, 2007). In addition, an increasing amount of international attention is being paid to health promotion and maternal child health (Chalmers et al., 2009) as evidenced by large-scale surveys to assess women's views about their childbearing experience and an increasing number of practice guidelines to tout nursing support as beneficial postpartum (Mantha, Davies, Moyer, & Crowe, 2008). For example, Health Canada has developed multidisciplinary guidelines on family-centered maternity and newborn care (FCMNC). The FCMNC guidelines suggest that postpartum care should (a) "support the developing relationship between the baby and his or her mother, father, and family"; (b) "support the development of infant feeding skills"; (c) "support and strengthen the mother's knowledge, as well as her confidence in herself and in her baby's health and well-being, thus enabling her to fulfill her mothering role within her particular family and cultural situation"; and (d) "support the development of parenting skills" (Health Canada, 2000). A recent Cochrane Review, "Support for Breastfeeding Mothers," offered that supplementary breastfeeding support should be considered as part of routine health service provision. Further, the review concluded that research is needed to identify the aspects of support that are the most effective to increase breastfeeding initiation, duration, and exclusivity (Britton et al., 2007). Mantha, Davies, Moyer, & Crowe, (2008) found that mothers themselves believed "they needed more support from nurses regarding infant feeding, postpartum teaching, and education" (p. 310). So, while there is general agreement that support for breastfeeding is the most common postpartum care need for women, it is also acknowledged that (particularly in those situations where mothers perceive that

they are having breastfeeding difficulties) healthcare professionals can be a negative source of support (Dennis, 2002).

It is generally acknowledged that childbearing women are emotionally vulnerable and need appropriate nursing support to breastfeed their infants (Chezem, 2003; Fooladi, 2006; Kendall-Tackett, 2007; McCarter-Spaulding & Horowitz, 2007). However, while *support* is often used as a catch-all label for nursing function in the postpartum setting, surprisingly, the concept of *nursing support for breastfeeding* remains imprecise: as evidenced by the apparent void in nursing research to illuminate the concept. In addition, while attempts to explicate the childbearing experience such as the Canadian Maternity Experiences Survey have been made, such studies are unable to capture women's multifaceted perceptions of postpartum issues due to limited survey designs (Chalmers et al., 2009).

Considering the prevalence of postpartum depression, and that breastfeeding initiation rates may be as high as 92% in Saskatoon (Neudorf et al., 2009), it is likely that many women who have chosen to breastfeed will experience some level of depression (McCarter-Spaulding & Horowitz, 2007). Clearly, it is important for nurses to understand the unique experience of the childbearing context given the emotional vulnerability of mothers and to explore the meaning of appropriate nursing support to breastfeed (Dunn, Davies, McCleary, Edwards, & Gadboury; Fooladi, 2006; Kendall-Tackett, 2007; McCarter-Spaulding & Horowitz, 2007). To do so will be to take the concept of nursing support for breastfeeding from the overused, perhaps even "trite and meaningless" (Hart & Rohweder, 1959), to the level of functional tool with the capacity to illuminate nursing practice and research issues (Rodgers, 2000) within the vulnerable postpartum context.

Research Objectives

Using a hermeneutic phenomenological approach, the objectives of this study will be twofold: first, to explore the lived experience of breastfeeding in women with postpartum depression; second, to co-create an interpretation of the meaning of breastfeeding support by blending understandings articulated by the researcher and the participants.

Approach: Hermeneutic Phenomenology

The basic philosophic assumptions of phenomenology are (a) that human perception (lived experience) offers important evidence of the world; and (b) that existence (being in the world) is "meaningful and of interest in the sense that we are always conscious of something" (Richards & Morse, 2007, p. 50). As the goal of this research is to understand the experience of breastfeeding in women with postpartum depression and the perception of nursing support within this context, hermeneutic phenomenology as inspired by the early work of Heidegger (1889–1976) and informed by the work of van Manen (1990) will be most appropriate. Key assumptions of hermeneutic (or interpretive) phenomenology are that people are self-interpretive beings, and that the social contexts of language, culture, and practice are shared (Wojnar & Swanson, 2007). Van Manen expounds upon these fundamental assumptions of phenomenology by asserting that "lived experience" occurs in the context of four existentialisms: lived time (temporality); lived space (spatiality); lived body (corporeality); and lived human relation (relationality) (1990, p. 102).

The philosophical perspective of hermeneutic phenomenology is well aligned to this researcher's personal philosophic orientation—which has also been influenced by Margaret Newman's theory of health as expanding consciousness (2008). Similar to van Manen's (1990) point of view, Newman describes her research approach as one of hermeneutic dialecticism:

hermeneutic to denote the search for meaning and understanding through interpretation, and dialectic because the process of the method (between researcher and participant) and the content of the search are in the form of dialogue (Newman, 2008). Nursing research evolves as "a caring relationship of pattern recognition that makes it possible for clients to understand the meaning of their experience and find their own way in the health process" (Newman, 2008, p. 94). Newman's approach may be summarized as follows: establishing a mutual process of inquiry, focusing interviews on finding meanings of lived experiences in participants' lives, sharing researcher interpretation of participants' life patterns, and facilitating insight into the meanings of those patterns. The result is an unfolding process of inquiry, feedback, and pattern recognition.

Akin to Newman's approach, van Manen (1990) outlines six research activities as essential to the practice of hermeneutic phenomenology:

1. Exploring a project of phenomenological inquiry of interest to the researcher (being thoughtful and fully committed to the topic). As a method, hermeneutic phenomenology acknowledges that linked to understanding is the researcher's interpretation of reality (Wojnar & Swanson, 2007). The reflexivity of this approach will give the researcher opportunity to use personal experience as a starting point for the research process, to continually reflect on findings and the interpretation of those findings, and to incorporate personal experience into the final text.
2. "Investigating the experience as we live it rather than as we conceptualize it" (van Manen, 1990, p. 30). For van Manen, data collection in the form of interviews or "conversations" provides a means to elicit rich, descriptive data within a social context (Lobiondo-Wood, Haber, Cameron, & Singh, 2009). As such, interviews will be carried out only after rapport is established.

3. Reflecting on essential themes so that we can explore the nature of the lived experience in question. Van Manen (1990) proposes that the four themes fundamental to phenomenology may help guide the characterization of the phenomenon in question: "lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality)" (p. 102).

4. "Describing the phenomenon through the art of writing and rewriting" (van Manen 1990, p. 32). The processes of reading, writing, and rewriting serve to organize the text and, according to van Manen, the crafting of a text becomes the *object* of the research process. An interpretation of the phenomenon of nursing support for breastfeeding in women with postpartum depression will be carried out by exploring themes in the text, as co-created between the participants and the researcher, and by creating a final phenomenological narrative.

5. Being strongly oriented to the fundamental question and not settling for preconceived opinions. Preconceptions and biases about what it means to *support* and *to be supported* (e.g., what it means to be a mother and/or nurse) will be addressed and included in the final text (Benner, 1994).

6. "Balancing the research context by considering parts and whole" (van Manen 1990, p. 33). Hermeneutic literature refers to this final point in van Manen's research approach as the *hermeneutic circle*; whereby, the circle becomes "a metaphor for understanding and interpretation, which is viewed as a movement between parts (data) and whole (evolving understanding of the phenomenon)" (Ajjawi & Higgs, 2007, p. 622).

As Ajjawi and Higgs (2007) describe the dynamic context of hermeneutic phenomenology, parts and whole confer meaning to one another such that understanding

becomes circular and iterative; in so doing, the process finds its potential to generate understanding of multidimensional, complex phenomena. For the present research, it is anticipated that this approach will elicit rich data, which would not be possible to glean using less flexible methods. Moreover, it is expected that the conversational tone of interviewing participants, as customary to the phenomenological approach, will encourage the development of authentic relationships between the researcher and participants: an important consideration given the sensitive nature of infant feeding topics and the vulnerability of women who are depressed. In addition, it is hoped that the dialectic nature of the interviews will minimize emotional distress to mothers, and that participation and dialogue surrounding the topic of breastfeeding and postpartum depression may even be therapeutic in nature. By establishing a mutual process of inquiry, which focuses interviews on understanding the meaning of the *lived experience* of breastfeeding with postpartum depression, and sharing the researcher's interpretation of these meanings, mothers may gain new insight into their postpartum experience.

Participants

Recruitment will occur in September 2011 via the Saskatoon Postpartum Depression Support Program, a community wellness program provided by Saskatoon Health Region. Sampling will be both purposeful (through involvement with the Postpartum Support Program) and theoretical (pending emergent material). An initial target number of two to five participants will be set; however, this number will remain flexible to accommodate data saturation. The priority will be to obtain rich, descriptive data in order to illuminate the phenomenon of support for breastfeeding among women who are depressed.

Inclusion criteria. English-speaking women of childbearing age (18–45 years of age), who are a part of the Saskatoon Health Region Postpartum Depression Support Program and who

have initiated breastfeeding for any amount of time will be invited to participate. Women who have been discharged from the program may also be included if they are identified as suitable candidates by the Postpartum Depression Support Program facilitator and indicate interest in participation. Breastfeeding will be defined as any current or previous breastfeeding experiences at any level as outlined by the Breastfeeding Committee for Canada (2004).

Exclusion criteria. Women who indicate a history of severe mental disability or who have been clinically diagnosed with postpartum psychosis will be excluded from the study. In the event that a participant reveals a history of severe mental illness or shows signs of postpartum psychosis throughout the course of the study, they will be advised to seek support and referral from their family physician. The option for follow-up via the Maternal Mental Health Program will be discussed, and the researcher will facilitate that process. In the interest of the mother, participation in the study will cease. None of the data collected from the participant will be used in the study: postpartum psychosis is beyond the scope of the present research. All data will be destroyed beyond recovery. Further exclusion criteria may be established as the study progresses pending emergent material.

Setting

Data will be collected through individual interviews at a location of the woman's choice, such as the participant's own home, the West Winds Primary Health Centre, or an office provided by the College of Nursing. The hope is that natural settings for the interviews will facilitate comfortable participation and elicit rich, spontaneous data. Interviews will be at the convenience of the participant (day or evening, weekday or weekend). Follow-up to the initial interview will be arranged either via e-mail or a face-to-face setting, according to the participant's comfort and convenience. Childcare will be offered to allow for uninterrupted time

for the interviews. Transportation to interviews will be included in the budget of this study. All interviews will be audiotaped and transcribed verbatim.

Procedure

Prior to the start of the research project, operational approval will be obtained from the Saskatoon Health Region. Women will be identified as possible candidates for this study through nurses responsible for facilitating the Postpartum Depression Support Program (namely registered nurses and the clinical coordinator of the Healthy & Home Program). The study purpose and design will be outlined to Healthy & Home staff, and their role, as the initial point of contact for participants, will be clarified.

Intake for the Postpartum Depression Support Program is done by telephone; however, because of the sensitive nature of postpartum depression and the emotional toll its symptoms can take on women, intake for this study will not happen until facilitators of the Postpartum Depression Support Program feel that a reasonable therapeutic relationship has been established (and would not be compromised through participation in the study). At that time, the facilitator of the Postpartum Depression Support Program will give the potential participant an informational flyer (H) so that they may contact the researcher by e-mail or telephone if they are interested in participating in the study. As determined by the facilitators, women who have shown signs and symptoms of postpartum psychosis or severe mental illness throughout the duration of their time with the Program will not be approached as candidates for this study.

Participants interested in being a part of this study will contact the researcher by telephone or e-mail at their own convenience after receiving the study flyer from a Postpartum Depression Support Program facilitator (see Appendix A for the guide to the first conversation regarding participation in the study). At that time, potential participants may indicate a

willingness to participate in this study; however, they will also be asked to give written consent. Written consent will be obtained from participants before interviews begin. Participants will be informed of their right to withdraw from the study at any time: The researcher will communicate the right to withdraw at various times throughout the study, including prior to the initial interview taking place, and at any subsequent follow-up interview (be that follow-up in person or by e-mail correspondence). Participants will also be informed of how the data will be used (as part of the researcher's thesis, in conference presentations, academic publications, and possibly a summary report to support organizations), and reported (as quotations to be accompanied by pseudonyms). See Appendix B, Written Consent.

The primary method of data collection will be a sixty-minute, face-to-face interview booked at a time and place convenient for the participants. Possible locations include participants' homes, an interview room at the Qualitative Research Centre on the University of Saskatchewan campus, or the West Winds Primary Health Centre. Interviews will be conversational in tone, audiotaped, transcribed verbatim, and analyzed according to emerging themes. The goal will be to create a collective interpretation of the experience of support, incorporating both the perceptions of the participants and the understanding of the researcher (Interview Guide, Appendix C). At the beginning of the initial interview, prior to the audio-recorder being turned on, the researcher will explain the study to the participant and obtain informed consent in writing. At this time, participants will be informed of their right to decide which questions they will answer and to end the interview at any time.

These initial interviews will serve to orient the researcher to each woman's postpartum experience and to build rapport. The focus of the face-to-face interview will be on the participant's experience of infant feeding with postpartum depression symptoms and the

participant's perception of professional nursing support of breastfeeding. However, due to the exploratory nature of the research, participants may introduce topics not included in the interview guide that they feel are important to understanding their experiences. Basic demographic information will also be collected from participants, such as age, family composition/marital status, and ethnicity, which will help in the description of the sample and increase the transferability of the research findings. Demographic questions (Appendix D) have been chosen because of their capacity to impact infant feeding decisions as outlined in the research literature.

A primary concern is that the emergent nature of this approach may cause participants to feel uncomfortable with the interview process. The researcher will be attentive to emotional issues that may arise, and with permission, will contact the participant's primary nurse or physician if additional follow-up or support is needed. A list of local resources including the Postpartum Depression Hotline and the Maternal Mental Health Program will be provided in case participants feel uneasy after the interview process. The researcher will also be sensitive to the fact that the interview process may be tiring. As such, interviews will be limited to 60 minutes and participants will be frequently reminded that they can take a break or end the interview at any time. In the event that the participant should indicate a risk of self-harm or harm to others, the researcher will be in immediate contact with the facilitator of the Postpartum Depression Support Program so that urgent steps may be taken to protect the participant. If the risk of harm is imminent, the researcher will facilitate transport of the participant to the Emergency Department at the Royal University Hospital, Saskatoon, SK.

All face-to-face interviews will be transcribed and translated verbatim by a professional transcriber, someone other than any of the researchers, who will be asked to sign a

confidentiality agreement (Appendix E). Participants will have the opportunity to review the final transcript of the interview, to acknowledge that what they said or intended to say is accurately reflected, and to add, delete, and make any changes they wish (Transcript Release, Appendix G). All findings and key themes will be reviewed with the participants in the follow-up interview or by e-mail correspondence according to the participant's preference. Adjustments will be made accordingly. If participants choose to withdraw from the study, at their request, any data contributed will be destroyed beyond recovery. The right to withdraw data from the study will apply until data collection is complete. After this, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw data.

The participants will also be invited to participate in follow-up correspondence by e-mail. E-mail will offer a convenient way to maintain contact with participants after the initial interview, to capture data that may have been forgotten during the initial interview, and to ask any additional questions, and/or clarify data from the first interview. E-mail interviews are advantageous because they allow participants control over the timing and location of interviews, which may be preferable for women who are attending to the needs of a new baby and struggling with the debilitating nature of postpartum depression. Participants will be asked to e-mail their reflections and responses to follow-up questions to the e-mail address provided by the researcher at any time over the four weeks that follow. Participants will be clearly told at the time of the initial interview, and in e-mail messages, of their option to not respond to any or all of the e-mail interview questions. If a participant decides not to participate in the e-mail component of the study, they will be asked to send an e-mail message confirming this decision, or to simply ignore the researcher's e-mails. Responses to e-mail interview questions from participants will be sent to

a password-protected e-mail address specifically dedicated to the study which will be accessed through a password-protected computer.

Once the researcher has received e-mails, participants' responses will be transferred into a Word document labeled with an alphanumeric code that only the researcher can connect with participants' personal information. The original e-mails will be deleted with only participants' addresses being stored separately on a master list of participants. In order to respect the needs and preferences of participants, the research design will be flexible. In the event that participants do not have access to e-mail, alternative arrangements will be made for a face-to-face follow-up interview, lasting up to 30 minutes.

At this stage in the research, nursing support will be broadly defined as resources and nursing services identified by breastfeeding women with postpartum depression, including those services as provided by nurses in hospital, or through the Healthy & Home Program, Breastfeeding Centre, Postpartum Depression Support Program, and Public Health.

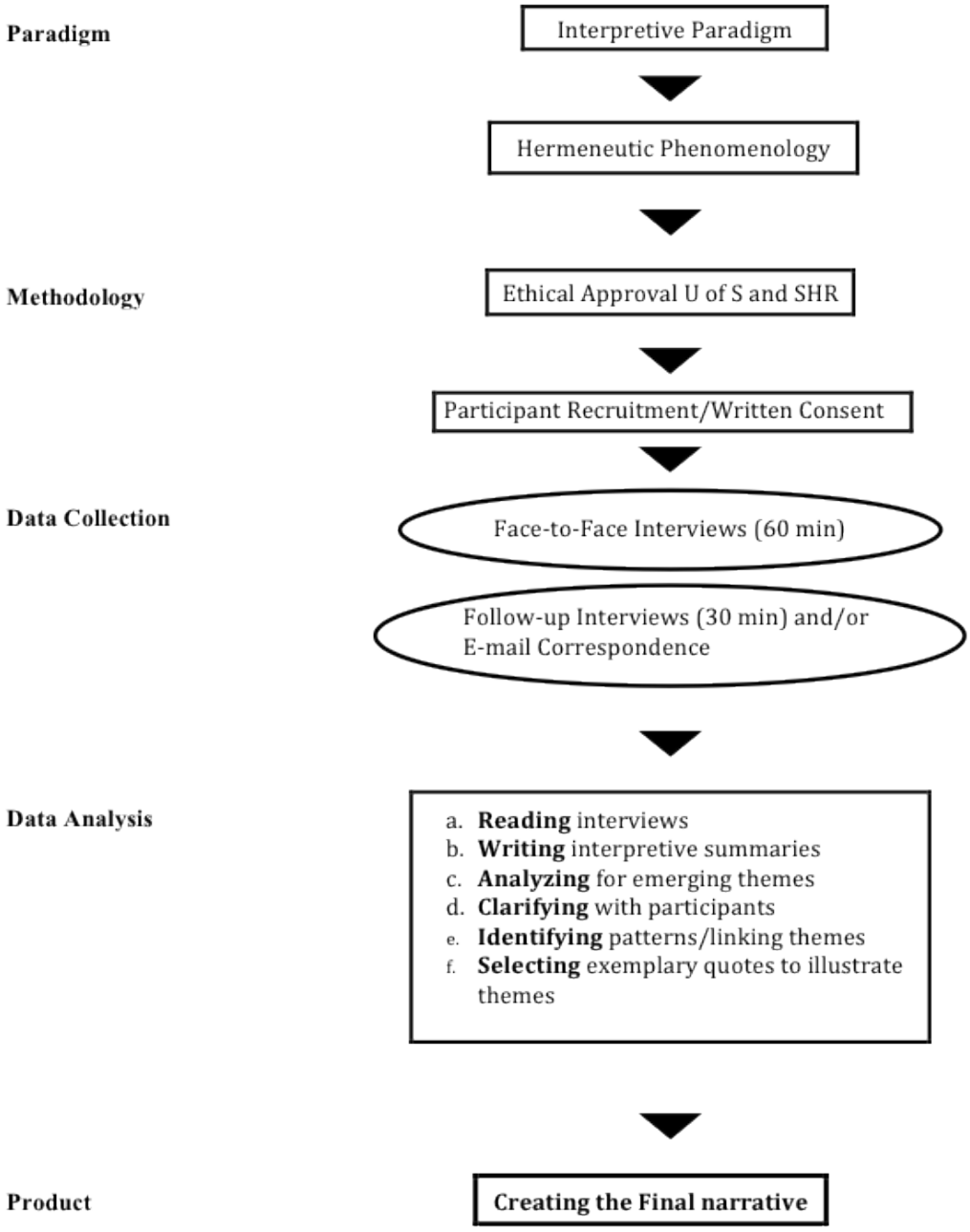
The researcher will also keep a journal of the research experience. The researcher’s journal will provide a compilation of critical experiences, reflections, decisions, and project history (Richards & Morse, 2007).

It is anticipated that the duration of the study will fall along the following timeline:

- January–April 2011: Gaining Entry: Practicum experience with the Postpartum Depression Support Program
- May–June 2011: Preparing Proposal
- July–August 2011: Obtaining operational approval from the Saskatoon Health Region and ethics approval for the University of Saskatchewan; on-going literature review

- September 2011–December 2011: Staff orientation to the research project; recruitment; data collection/interviews
- September 2011–January 2012: On-going transcription, data analysis, and preparation of findings
- January 2012–December 2013: Knowledge translation activities including presentations, preparation of materials for women and professionals, and publication

Figure 1. Overview of the Research Process



Data Analysis

Data analysis will be congruent with guidelines outlined in the literature conducive to inquiry from the perspective of hermeneutic phenomenology. Wojnar and Swanson (2007) explicate the fundamental features of data analysis from an interpretive approach as based on the work of Diekelmann, Allen, and Tanner (1989). An adapted template of this step-wise process will be used for the present study including (a) reading interviews to gain a general understanding of the "support" phenomenon; (b) writing interpretive summaries of the interviews and coding any emerging themes; (c) analyzing groups of transcripts for emerging themes (including on-going appreciation of differences, ambiguity, and uniqueness in data making); (d) clarifying interpretation with participants to clearly articulate meanings and understandings; (e) identifying patterns, linking themes, and identifying repetition of themes from within and between cases; and (f) selecting exemplary quotes to illustrate themes.

Rigour

Quality research requires consistency in operating within the philosophical traditions of the research paradigm, the rigorous use of systematic data collection and analysis, and transparency of documentation (Lincoln & Guba, 2000). Every effort must be made to achieve congruence between the adopted paradigm and selected methods (Ajjawi & Higgs, 2007).

In order to achieve rigour in the proposed study, the researcher will strive for inductive inquiry (Richards & Morse, 2007) and maintain on-going analysis of the appropriateness of the study's method. The philosophic underpinnings of hermeneutic phenomenology are well-suited to inductive inquiry, and the hermeneutic approach actively seeks understanding as co-created throughout the study by the participants and the researcher. Further, hermeneutic phenomenology as a method allows for "choosing directions and exploring techniques,

procedures, and sources that are not always foreseeable at the outset of a research project" (van Manen, 1990, p. 162). It is anticipated that the present study design will need to be flexible in order to accommodate emergent themes.

Valid representation of data will be sought throughout this study by using both purposeful and theoretical sampling to accommodate emergent themes (Richards & Morse, 2007). As well, every attempt will be made to obtain thick, descriptive data to the point of saturation. Member checks will be conducted in order that participants have the opportunity to clarify and ensure the interpretation of their own narratives. An audit trail will be maintained by the researcher in the form of comprehensive, dated field notes.

Ethics

Ethical approval will be obtained from the University of Saskatchewan Behavioural Research Ethics Board. All participants will receive an information package explaining the purpose and process of the study and describing the potential risks and benefits of participating in the study. A consent form will be included in the information package for signature, as will contact information, should participants have any questions or concerns during the study. Copies of all documents including the list of participant names, personal information, and consent forms will be kept in a locked filing cabinet at the University of Saskatchewan, College of Nursing for five years. Only the principal researcher will know the names of the participants. The final narrative will protect the identities of the participants via the use of pseudonyms, and alteration of physical context as needed.

The context of this study may raise ethical issues given the vulnerability of postpartum women and their infants. The researcher will be attentive to emotional issues that may arise, and with permission, will contact the participant's primary nurse or physician if additional follow-up

or support is needed. The researcher will also be sensitive to the fact that the interview process may be tiring. As such, interviews will be "participant driven," limited to 60 minutes, and participants will be reminded that they can take a break or end the interview at any time.

Impact and Plans for Knowledge Transfer and Exchange

The health problems of infants and children related to a lack of breastfeeding and/or short duration of breastfeeding are well-documented, as is the view that the key to protecting breastfeeding is continued support for mothers. There is also a plethora of research to confirm that an understanding of the nature of maternal difficulties within the context of postpartum depression is imperative to the health of mothers and infants; however, the meaning of appropriate support for breastfeeding in mother's postpartum depression remains unknown. Therefore, the goals of this study will be to explore the experience of breastfeeding in women with postpartum depression and to co-create an interpretation of the meaning of nursing support for breastfeeding. As our current health care environment continues to evolve to include an emphasis on health promotion and maternal child health, the importance of this work must not be underestimated. Whether the setting is acute or community based, huge challenges are evident in this area and it is expected that the proposed study will provide the groundwork for continued awareness, understanding, and research in the realm of maternal child health and maternal mental health.

Knowledge translation and exchange is a process that includes synthesis, dissemination, and ethically sound application of knowledge to improve the health of Canadians (Canadian Institutes of Health Research, 2010). Knowledge translation and exchange for the proposed research will begin at the outset of the study as connecting with relevant stakeholders will be necessary to gain entry into the study population. Stakeholders include the management and staff

of the postpartum unit at the Royal University Hospital, and the Healthy & Home Program and its affiliates, the Breastfeeding Centre and the Postpartum Depression Support Program. Knowledge gleaned from this study will also be shared with other community stakeholders including, the Healthy Mother Healthy Baby Program, Public Health Nurses, and Mental Health Services. As the aim of the current proposal is well aligned to the newly formed Maternal Mental Health Program in Saskatchewan, which has developed in response to the growing awareness of antenatal and postpartum depression in our community, it is also anticipated that findings will be disseminated via this source.

At a provincial level, findings will be offered for presentation and discussion sessions to provincial breastfeeding centres and hospitals, to the Saskatchewan Lactation Consultants Association, and to women's groups such as Breastfeeding Matters. The results of the research will be submitted for presentation at the Life Sciences Conference at the University of Saskatchewan, the Women's and Children's Health Conference through CNE, the Western Perinatal Research Meeting, and the Canadian Association of Perinatal and Women's Health Nursing. A publication will be submitted to a far-reaching journal in the field, such as the *Journal of Human Lactation* or the *Journal of Obstetric, Gynecologic, and Neonatal Nursing*. It is also anticipated that findings will be presented as a seminar for students and faculty of the College of Nursing.

Funding and Positioning for National Success

In 2010, I received a Frederick Banting and Charles Best Canada Graduate Scholarship through the Canadian Institutes of Health Research. This award allowed me to focus my attention on Master's study and I have come to a fuller appreciation of the need for nursing research to inform postpartum clinical practice. Financial support was also received in 2011

through a research grant from the Canadian Association of Perinatal and Women's Health Nurses. In addition, funding as provided by the Muriel E. Kavanagh Memorial Fund and the Alice Caplin Nursing Fund, as well as a Graduate Teaching Fellowship from the University of Saskatchewan, supported my studies and allowed me to concentrate on completing this research in a timely manner.

For the future, I see my contribution to nursing and health care in Saskatchewan evolving to include elements of research, education, advocacy, and leadership. I am confident that the proposed study will increase awareness and understanding of breastfeeding women with postpartum depression so that future research will have the capacity to build on these findings. The need for this research extends well beyond the borders of Saskatchewan, and, through active knowledge translation and exchange activities, it is anticipated that this work will fill a significant gap in the literature at a national and international level.

Research Team

I am a Master of Nursing student who also works on the postpartum unit at Royal University Hospital. I have completed my Master's Degree practicum with the Postpartum Depression Support Program in Saskatoon (operated within the Saskatoon Health Region) where recruitment for the present study will take place. My passion for, and work in, maternal/child health care gives me the capacity to ensure that the research is done with the women's mental and physical status in focus. In addition, my experience will allow me to respond appropriately to participants' reflections surrounding the postpartum experience.

Thesis supervisor, Dr. Angela Bowen, Associate Professor of the College of Nursing, and Associate Member of the Department of Psychiatry at the University of Saskatchewan, has extensive research experience with women from the proposed study population. Dr. Bowen's

research includes the areas of reproductive and women's mental health, and through this work, she has spearheaded the development of the Maternal Health Strategy: Building Capacity in Saskatchewan project, which works to improve awareness, develop support services, and make policy recommendations for women who suffer from depression during pregnancy and postpartum. The Maternal Mental Health Program has a psychiatrist, a psychologist, and a registered nurse, who may be made available to women at any time throughout the study period, if necessary.

Dr. Lorraine Holtslander, committee member, brings expertise in qualitative methods and care of the family. Dr. Holtslander has been active in clinical practice as a home care nurse for over 21 years and has conducted substantial research from a qualitative approach.
Dr. Holtslander will provide advice, support, and assistance to me as the research study progresses.

Helen Irwin, committee member, is a registered nurse and an International Board Certified Lactation Consultant. As clinical coordinator of the Healthy & Home Program and its affiliate, the Postpartum Depression Support Program, Ms. Irwin brings her clinical expertise with regard to the impact of maternal depression and its management via nurse-facilitated support groups. Ms. Irwin's own master's thesis explored the subject of breastfeeding from a qualitative perspective, and it is anticipated that this experience will also inform my approach to the present study.

Dr. Norma Stewart, committee chair, is an experienced academic researcher and a PhD psychologist. Dr. Stewart was the Associate Dean of the College of Graduate Studies and Research at the University of Saskatchewan until 2008, and has mentored many people, from students through to mid-career scientists.

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APPENDIX A: INFORMATION REGARDING PARTICIPATION

The first contact for potential participants will be done by the facilitator (a registered nurse) of the Postpartum Depression Support Program. The following script will be used after potential participants have contacted the researcher in order to determine consent to participation in the study. The time, date, and name of participant will be documented.

Hello, my name is Tonia Olson and I am a registered nurse doing a Master's thesis through the College of Nursing at the University of Saskatchewan.

The purpose of my study is to describe and understand the experiences of mothers who have breastfed their babies, and at the same time struggled with symptoms of depression. Any amount of breastfeeding experience is of interest. I am asking for women who are a part of, or who have recently been discharged from, the Saskatoon Postpartum Depression Support Group. Because the focus of this particular project is on postpartum depression, women who have suffered from postpartum psychosis or severe mental illness will be excluded from the study. Would you like to hear more?

The interview will be guided by some questions, but you will be encouraged to share whatever information you feel comfortable talking about with regard to your breastfeeding experience. The interview will last approximately 60 minutes. It will be audiotaped, and held at a time and place that is convenient for you. You will also be invited to participate in a follow-up face-to-face interview or to correspond with me by e-mail. Hopefully, e-mail will give you a convenient way to maintain contact with me after our first conversation so that you can add any thoughts that you may have forgotten during our first interview. I may also ask additional questions, and/or clarify data from the first time we spoke. You will always have the option not

to correspond by e-mail. If you do not have access to e-mail, arrangements will be made for a face-to-face follow-up interview, lasting up to 30 minutes. The total time for this study may be up to three hours (one hour for the first visit, up to one half hour for the second visit, and/or time to e-mail). All information will be handled confidentially. Your participation in this study and sharing your story will enable us to better meet the needs of women who access postpartum support services in the Saskatoon Health Region.

If you have any questions, you can contact me, Tonia Olson, at ppd.experience@usask.ca. My research supervisor Dr. Angela Bowen can also be contacted by phone at 306-966-8949. Any questions regarding your participation in this research may be addressed to the University of Saskatchewan Research Ethics Office at 306-966-2084. I will give you a reminder call the day before the interview.

The invitation to participate was read and explained over the phone to

_____(Participant's name)

on _____ (date, time). The participant has knowledge of, and appears to understand, the nature of the research project. Yes ___ No ___

Invitation to participate: Accepted ___ Interview date: _____

APPENDIX B: WRITTEN CONSENT FORM

Consent to be a Research Participant

Please read this consent form carefully, and feel free to ask questions you might have.

Who is conducting this study? Tonia Olson, College of Nursing, University of Saskatchewan, (306) 966-8949. Dr. Angela Bowen, Thesis Supervisor, College of Nursing, University of Saskatchewan, (306) 966-8949.

Why is this study being conducted? This study is being done as a part of a Master's thesis. Mothers who feel depressed after the birth of their baby may be at an increased risk for breastfeeding difficulties, and for stopping breastfeeding their babies before they had planned to. It is hoped that this research will help to improve support services offered to these women and their infants.

What will the study involve? Your participation is voluntary. We would like to invite you to participate in research by being interviewed about your experiences of breastfeeding, support, and postpartum depression. The study will involve a 60-minute interview with the researcher. Your interview will be audiotaped, transferred to paper, and verified with you. You will also be invited to participate in a face-to-face follow-up to the initial interview, of no more than 30 minutes, or to correspond by e-mail so that you can add any thoughts that you may have forgotten during our first interview. I may also ask additional questions, and/or clarify data from the first time we spoke. You will always have the option not to correspond by e-mail. The total time for this study may be up to 3 hours (one hour for the first visit, up to one half hour for the second visit, and/or time for e-mail correspondence). Information may be used in publishable papers and presentations to improve quality of healthcare services.

Are there possible risks of being involved in this study? Answering the questions may be tiring. You do not have to answer any questions you don't want to. You can stop being in the study any time you want. If you get tired, don't feel well, or become upset, you can take a break at any time or end the interview. You will be encouraged to continue attending the Postpartum Depression Support Program throughout the duration of the study, as participation in this study is not intended to replace the supports offered through that program. If you feel that additional counselling is necessary, I can help to put you in contact with services as offered through the Mental Health Program in the Saskatoon Health Region, with your permission.

Are there benefits of being involved in this study? There are no intended benefits associated with this study. Although there may be no direct benefits, many women find that discussing their experiences can be helpful. Importantly, studies of this type will enable us to better understand the experience of breastfeeding with postpartum depression so that we can make improvements to support and care services offered to women like you.

How will my information be stored? Your answers to the questions, audiotapes, and e-mail correspondence will be stored on a password-protected computer by the researcher, in a locked office at the College of Nursing, University of Saskatchewan, for at least five years. Only the researcher will be able to look at the information. Signed documents will be stored separately from transcripts and audiotapes in a locked cabinet in the office of Dr. Angela Bowen at the University of Saskatchewan for five years. You will have the opportunity to review the transcript of the interview to make any changes that you feel are needed. If the researcher decides to destroy the data after five years, it will be destroyed beyond recovery.

How will my confidentiality be maintained? The researcher will take steps to ensure that confidentiality is maintained to the highest degree possible. Tape recordings, transcripts (all face-to-face interviews will be transcribed and translated verbatim), and e-mail correspondence will be strictly confidential. Given the personal nature of the research topic, some personal information will be connected with certain pieces of data. For example, your age, and the amount of time that has passed since your baby's birth, may be associated with quotations from interviews; however, all participants will be assigned pseudonyms to protect their identity. Personal information such as phone numbers, e-mail and mailing addresses, and organizational affiliations will be kept confidential and any information that may identify third parties associated with you will be deleted or altered (i.e., names of doctors, family members, etc.). Responses to e-mail interview questions will be sent to a password-protected e-mail address specifically dedicated to the study that will be accessed through a password-protected computer. Once the interview is transcribed, you will have an opportunity to review it and add, delete, and make any changes that you wish.

The researcher will not disclose information about you to a referring agency except, as required by law, in the event that you should indicate a risk of self harm or harm to others (including your baby).

Will taking part in the study cost me anything? No. The study will be conducted at the location of choice: at your home, at the West Winds Primary Health Centre, or at the University of Saskatchewan, according to your comfort and convenience. Transportation to the interviews if will be provided as necessary. Childcare will also be provided and paid for as needed.

Will I have the right to withdraw from the study? You have the right to refuse to participate in research, to refuse to answer individual questions, or not to have your information used for research at any time and this will in no way affect any clinical services that you are receiving. If you choose to withdraw from the study, any data you have contributed will be destroyed beyond recovery at your request. Your right to withdraw data from the study will apply until data collection is complete. After this, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

Who do I contact if I have questions? If you have any questions about the study, please do not hesitate to contact the researchers at the contact numbers provided. The University of Saskatchewan Behavioural Sciences Research Ethics Board approved this study on August 10, 2011. Any questions regarding the ethics of this researcher, or participant rights, can be forwarded to the Research Ethics Office at 306-966-2084. You can call collect from out of town.

Consent to Participate: I have read and understood the above. I have had an opportunity to ask questions and my questions have been answered to my satisfaction. I consent to participate in the present study, understanding that I may withdraw at any time. A copy of this consent form has been provided for my personal records.

I wish to review the transcript of this interview: yes ___ no ___

(Signature of Participant) (Date)

(Signature of Researcher) (Date)

APPENDIX C: INTERVIEW PROCEDURE AND PROTOCOL

Face-to-Face Interview: Overview and Context:

Participants will consist of women 18–45 years of age, who are accessing, or have been recently discharged from, the Saskatoon Postpartum Depression Support Program and who have breastfed their infants for any amount of time. Tonia Olson, a Master's student from the College of Nursing at the University of Saskatchewan, will perform all interviews.

Preamble:

The researcher will describe and give background on the study; explain interview consent form; inform participants that they will be assigned a pseudonym in order for their identity to remain confidential; describe the types of questions that are going to be asked; inform participants of their right to refuse to answer any questions and their right to withdraw at any point during the research; and emphasize that there are no specific answers to the questions.

Interview Guide:

1) Participants will be asked to share a little bit about themselves as an introduction. If any background information is known, it may be used to begin conversation (e.g., How long have you lived in Saskatoon?) Demographic questions may be asked at this time or may be saved for the end of the interview, as deemed appropriate.
2) Tell me about your prenatal experience. Probes: Had you struggled with depression previous to your pregnancy? When did your feelings of depression start? Do you have a specific memory that you would be willing to share with me? What were/are your symptoms? What did being pregnant and depressed look or feel like for you? Are you currently taking an antidepressant? If yes, for how long have you been taking it?

3) When did you make the decision to breastfeed your baby? Probes: Did you go to prenatal classes? Were the classes helpful with regard to your questions about infant feeding? Can you remember an example of something you learned either about postpartum depression or infant feeding from the classes that you could share with me?
4) Tell me about your hospital experience. Probe: Did your feelings of depression start in the hospital, tell me about what that felt like for you. Do you have a specific memory that you would be willing to share?
5) Describe your experience with breastfeeding? Probes: Had you breastfed other children prior to this baby? What was that experience like? Tell me what it was like in the first hours with your baby? How did you feel? How did you feed your baby immediately after birth? Did anyone help you to breastfeed your baby? Did you remember if you felt supported/not supported to breastfeed in the hospital? Do you have a specific example, story, or memory from the hospital that you would be willing to share with me?
6) Describe some of the positive or negative aspects to breastfeeding. Probes: What areas of your life have been affected by the way you have chosen to feed your baby? How has your daily routine changed, if at all, as a result?
7) What role did other people play in your decision to breastfeed? (E.g. spouse, partner, mother, family, friends, your doctor, nurses, lactation consultants, midwives, and other community healthcare workers.) Probes: Who are/were the most important/supportive people in your postpartum/infant feeding journey? Do you think that nurses could have been more supportive of you with regard to your feelings of depression, or with regard to helping you to breastfeed? If so, what kinds of things could they have done to provide you with more support?

8) What/who would you consider as being supportive in your postpartum experience?
9) What type of support do you feel was most helpful with breastfeeding? What have nurses done that has felt supportive, or not supportive, when it comes to breastfeeding with postpartum depression?
10) When did you make the decision to stop breastfeeding? Would you be willing to tell me more about that decision?
11) Do you feel that there is a connection between formula feeding or breastfeeding and your feelings of depression? Can you think of and describe any examples for me?

Final question:

1. Do you have anything to add?

*These questions will provide preliminary a guide for the interviews; however, the researcher may also include questions that are specific to each participant and ask for elaboration on what a participant has said. Given the iterative nature of the phenomenological approach, participants will also be free to introduce their own topics during the interview and questions may be modified as appropriate and as relevant data emerges and unfolds.

Follow-up Face-to-face or E-mail Interview

Each participant will be sent follow-up email interview questions or will meet the researcher again within the four week time period following the initial face-to-face interview. Tonia Olson, Master's student from the College of Nursing at the University of Saskatchewan, will send all e-mail interviews.

Preamble: Interviewer will review the objectives of the study, informed consent to participate and right to refuse to answer any questions or withdraw from the study, the assignment of pseudonyms to ensure confidentiality, and the fact that questions about the research are welcome.

1) Have you thought of anything about your experience of breastfeeding/infant feeding with postpartum depression that you wished you had said when we met for the face-to-face interview? An infant feeding story or memory that you forgot to talk about in our initial interview that you would be willing to share with me?
2) Over the last two weeks, how, if at all, has the way you feed your baby affected your everyday life including your feelings of depression? Have you experienced these effects physically, psychologically, and/or socially?
3) How have you managed the demands of caring for your infant while feeling depressed this week?
4) What infant feeding related concerns do you have at this time? Do you feel that health care services and/or support are available to you to help you manage these concerns?
5) If you could help other women after this experience (women who are trying to breastfeed while feeling depressed), what kinds of things would you see as being helpful or supportive?

APPENDIX D: DEMOGRAPHIC GUIDE

1. How old are you? _____
2. How old is your baby today? _____
3. How many children do you have? _____Do your other children live with you? _____
4. What is your marital status?
    a) Single, never married
    b) Married
    c) Living with partner, but not married
    d) Divorced/separated
    e) Have partner but not living together
    f) My current partner is not the father of this infant
    g) Widowed
5. Do you have a support person that you can count on? _____

   Was this person with you at the time of the baby's birth? _____
6. Have you ever been diagnosed or are you currently receiving treatment for any of the following mental illnesses?
    a) Depression
    b) Generalized anxiety disorder
    c) Panic attacks
    a) Post-traumatic stress disorder (PTSD)
    b) Bipolar disorder (Type I or II)

7. How would you describe your ethnic background?

    a) White

    b) First Nations

    c) Black

    d) East Indian

    e) Asian

    f) Other

8. What is the highest level of education you have completed?

    a) Elementary

    b) High school

    c) Post-secondary school

9. What is your household income?

    d) Below $25,000

    e) Between $25,001 and $55,000

    f) Over $55,000

    g) Chose not to respond

APPENDIX E: CONFIDENTIALITY AGREEMENT

I, _____, agree to keep all information from the audiotaped interviews and e-mail correspondence for "Mother's Milk and Mother's Tears: A Phenomenological Study of Breastfeeding Experiences in Women with Postpartum Depression" in the strictest confidence.

_____ _____

Transcriber Signature Date

_____ _____

Researcher Signature Date

APPENDIX F: DEBRIEFING FORM

Thank you for your participation in the study of "Mother's Milk and Mother's Tears: A Phenomenological Study of Breastfeeding Experiences in Women with Postpartum Depression." The purpose of this study was to describe and to better understand the experience of women who breastfeed their infants while suffering from symptoms of depression. Your co-operation and participation are greatly appreciated.

If you feel you need additional support, please consider accessing some of the resources listed below, or call the Maternal Mental Health Program at 306-966-8229. If you have any further questions regarding the research, please feel free to contact me at ppd.experience@usask.ca

Participant Resources:

Maternal Mental Health Program: Nurse	655-0498
Maternal Mental Health Program: Office	966-8229
Postpartum Depression Support Program Hotline	221-6806
Mental Health Services-Intake	655-7950
Family Services Saskatoon	244-0127
Mobile Crisis Service	933-6200
Primary Health Unit: The Health Bus	244-8347

APPENDIX G: TRANSCRIPT RELEASE

I, _____, have reviewed the complete transcript of my personal interview for "Mother's Milk and Mother's Tears: A Phenomenological Study of Breastfeeding Experiences in Women with Postpartum Depression." I have had the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Tonia Olson. I hereby authorize the release of this transcript to Tonia Olson to be used in the manner described in the consent form. I have received a copy of this Transcript Release Form for my records.

_____ _____

Participant **Date**

_____ _____

Researcher **Date**

APPENDIX H: INVITATION TO PARTICIPATE

An Invitation to Mothers to Participate in a Qualitative Study

- **Have you felt depressed after the birth of your baby?**
- **Have you breastfed your baby for any amount of time?**
- **Are you willing to share your experience in a conversation style interview and follow-up?**

Purpose: To learn more about how women affected by postpartum depression manage the responsibility of infant feeding and to better understand how healthcare professionals can support postpartum women.

Estimated time commitment is 1.5 to 3 hours over four weeks, but may vary.

If you are attending Saskatoon Health Region Postpartum Depression Support Group and are interested in learning more about this study, please contact **Tonia Olson**, RN MScN candidate, College of Nursing by phone: **(306) 966--8949**

In the event that a participant reveals severe mental illness or exhibits signs of postpartum psychosis further supports as provided by the Maternal Mental Health Program will be discussed.

*You are under no obligation to participate if you call

UNIVERSITY OF SASKATCHEWAN

MANUSCRIPT

Mother's Milk and Mother's Tears: Breastfeeding Experiences in Mothers with Postpartum Depression

Tonia Olson, University of Saskatchewan

Author Note

Tonia Olson, College of Nursing, University of Saskatchewan; Lorraine Holtslander, Associate Professor, College of Nursing, University of Saskatchewan; Angela Bowen, Associate Professor, College of Nursing and Associate Member Department of Psychiatry, University of Saskatchewan.

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Correspondence concerning this article should be addressed to Tonia Olson, 107 Wiggins Rd., Saskatoon, SK, S7N 5E5 Canada E-mail: tonia.olson@usask.ca

ABSTRACT

Objectives: To explore the lived experience of breastfeeding in women with postpartum depression and to elucidate the concept of nursing support for breastfeeding within that experience.

Design: In-depth, audio-taped interviews, transcribed verbatim, and analyzed for emergent themes.

Setting: Participants' homes and a primary health care centre in Saskatoon, Saskatchewan.

Participants: Five women, ages 24–33, within the first year of the birth of a new baby. All women were accessing support as provided by a local postpartum depression support program

Methodological Approach: Qualitative. Hermeneutic phenomenology.

Results: The lived experience of breastfeeding with postpartum depression presented itself across interviews as overarching patterns, which are expressed by the following four themes: making the decision to breastfeed and having great expectations; learning the moves and wanting reassurance (establishing the breastfeeding relationship); breastfeeding in the dark (maintaining the breastfeeding relationship while trying to manage the symptoms of depression); and keeping it under wraps and waiting it out (the issue of support).

Conclusion: The mothers in this study valued the breastfeeding relationship when it went well; however, breastfeeding difficulties intensified symptoms of depression. When faced with the debilitating symptoms of postpartum depression, mothers needed ongoing support from health care professionals and loved ones to continue to breastfeed. Women need anticipatory guidance to be prepared for the demands of motherhood. Women who are at risk for postpartum depression need appropriate treatment throughout the perinatal period and beyond.

Keywords: breastfeeding, postpartum depression, intervention, qualitative.

Mother's Milk and Mother's Tears: Breastfeeding Experiences in Mothers with Postpartum Depression

Organizations responsible for setting guidelines for infant feeding, such as the World Health Organization, recommend exclusive breastfeeding (no other food or drink) for the first six months of life for healthy term infants, and continued breastfeeding, with the introduction of complementary foods, for up to two years of age or beyond (American Academy of Pediatrics, 2012; World Health Organization [WHO], 2012). Yet, regardless of knowledge that human lactation is a normal physiological response to pregnancy and birth, and regardless of awareness of the risks associated with artificial baby milk (Duijts, Jaddoe, Hofman, & Moll, 2010; McNiel, Labbok, & Abrahams, 2010), Canadian and U.S. trends in breastfeeding rates remain relatively stagnant. For example, while approximately 75% of mothers in the U.S. initiate breastfeeding, only about 13% of babies are exclusively breastfed to six months (U.S. Department of Health and Human Services, 2011). In Canada, the breastfeeding initiation rate is reported to be as high as 90.3%, with exclusivity to six months at 14.4% (Chalmers et al., 2009). As infants continue to suffer consequences related to a lack of breastfeeding and/or short breastfeeding duration, promoting, protecting, and supporting breastfeeding remains an important primary health care strategy (U.S. Department of Health and Human Services, 2011; WHO, 2012).

Complicating the discussion surrounding infant feeding is maternal mental health and research has begun to address maternal depression across the perinatal continuum (Bowen, Bowen, Butt, Rahman, & Muhajarine, 2012). Estimates for the prevalence of postpartum depression (PPD) vary widely: from 8.1% (Bowen et al., 2012) to a recent systematic review that has reports a period prevalence of 19.2 % of U.S. mothers within the first postpartum year (Gavin et al., 2005).

Growing attention is being paid to the interplay between infant feeding practices and PPD, but whether there is directionality in the relationship remains contentious (Bogen, Hanusa, Moses-Kolko, & Wisner, 2010; Dennis & McQueen, 2009). Public and professional resistance to breastfeeding support is often expressed as a concern about unwelcome pressure on mothers to breastfeed when they are not so inclined; some health care professionals argue that if mothers are depressed, breastfeeding poses an "unnecessary burden" (McCarter-Spaulding & Horowitz, 2007, p. 10). On the contrary, the literature suggests that when breastfeeding goes well, it may protect maternal mental health (Donaldson-Myles, 2011; Kendall-Tackett, Cong, & Hale, 2011). Thus, it may be inaccurate to assume that mothers with depression should not continue, or may not be able to sustain, breastfeeding (McCarter-Spaulding & Horowitz, 2007). In addition, it has been found that depressive symptoms negatively impact both breastfeeding duration (Akman et al., 2008; Nishioka et al., 2011) and breastfeeding exclusivity (Dennis & McQueen, 2009). Similarly, women who have negative early breastfeeding experiences or difficulties may be at a greater risk for PPD (Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011).

The purpose of this study was to elucidate dimensions of nursing support for breastfeeding, as identified by a sample of women struggling with PPD. The objectives were twofold: (1) to explore the lived experience of breastfeeding in women with PPD; and (2) to co-create an interpretation of the meaning of breastfeeding support by blending understandings articulated by the researcher and the participants.

METHODS

We used a qualitative approach as inspired by the traditions of hermeneutic phenomenology (van Manen, 1990) and undertaken from the perspective of a postpartum nurse in an acute care setting. Phenomenology was well suited for this study, not only because it allowed for a description of the experience of breastfeeding with PPD from the unique perspectives of the women interviewed, but also because it accommodated the notion that all data was an inevitable consequence of interpretation, from the mothers' memory and retelling of their experiences, to the researcher's exploration for meaning in their words, to the final thematic representation of that meaning. The researcher's intent throughout was to listen to the women, and to respect their voices.

PROCEDURE

A purposive sample of mothers attending a postpartum depression support program was recruited in September 2011. Women were identified as possible candidates for this study by facilitators of the program. Because of the sensitive nature of PPD and the emotional toll of its symptoms on women, intake for this research did not occur until the facilitators were confident that a therapeutic relationship had been established and that it would not be compromised through participation in the study. Eligibility criteria required either current or previous breastfeeding experience. Women who indicated a history of severe mental disability or who had been clinically diagnosed with postpartum psychosis were excluded from the study. Participation was voluntary; participants were assured that the researcher would not be involved in their care and that their participation in the research would not affect their access to services within the program. Written consent was obtained from participants before interviews began.

Data was generated in an hour-long open-ended interview with each mother. Each mother chose the time, place, and date of her interview. Mothers were asked to describe their birthing stories, giving particular attention to the topics of infant feeding and their feelings of depression. Interviews were audio recorded and transcribed verbatim by a professional secretary. Ethical approval was received from the university's behavioral research ethics board, and operational approval was received from the local health region.

DATA ANALYSIS

Analysis was accomplished through the following research activities: (1) each transcript was read several times for preliminary impressions of the interviews; (2) recurring ideas across interviews and relevant patterns were identified; (3) particularly descriptive statements were extracted from the transcripts and organized using traditional conceptual files (Loiselle, Profetto-McGrath, Polit, & Beck, 2004); (4) the meaning of statements was derived by clustering into thematic groupings; (5) the theme statements and their interpretive summaries were written and rewritten several times.

The dynamic nature of the hermeneutic process, whereby parts and whole confer meaning to one another such that understanding is iterative (Ajjawi & Higgs, 2007), helped generate understanding of breastfeeding within the context of depression. This iterative process was integral to the determination of themes and to the creation of the interpretive summaries.

RIGOR

The researcher was aware of assumptions and biases and made every attempt to capture the essence of data as co-created between researcher and mothers (van Manen, 1990). In so doing, the researcher's personal experiences of breastfeeding with PPD (as mother) and supporting breastfeeding (as nurse) were not so much "bracketed"—as is common in traditional

phenomenological approaches (Dowling, 2007)—as acknowledged. Purposeful sampling ensured valid representation of data. Credibility was augmented by asking women to tell their birthing stories and experiences with breastfeeding and PPD with little interruption (van Manen, 1990). Participant quotes are included in the presentation of results to demonstrate fittingness of themes.

RESULTS

Five mothers participated in the study: Greta, Jane, Jessica, Mary, and Patti. Pseudonyms have been assigned to protect the mothers' identities. At the time of the interviews, all of the mothers were taking antidepressants and four of the five mothers were still breastfeeding their babies. All women were attending a local postpartum depression support program and had given birth to healthy term infants within the last four to ten months. Three of the five interviews took place in the mothers' homes and two of the interviews were held at the primary health care center where the support group meets. All interviews took on their own dynamic and the mothers openly shared their perceptions of infant feeding, depression, and support.

INSERT TABLE 1 ABOUT HERE

The experience of breastfeeding with PPD manifested itself in individual mothers and across all interviews as a journey from making the decision to breastfeed prenatally into birth to the postpartum experience at the time of each interview. The themes emerged are thus related on a time continuum: (1) making the decision to breastfeed and having great expectations; (2) learning the moves and wanting reassurance (establishing the breastfeeding relationship in hospital); (3) breastfeeding in the dark (maintaining the breastfeeding relationship while trying to manage the symptoms of depression); and (4) breastfeeding under wraps and waiting it out (seeking support).

Theme One: Making the decision to breastfeed and having great expectations

For all five mothers, pregnancy was a time of preparation and high hopes. They spoke of the excitement of preparing for the birth and of their decision to breastfeed. Mothers expressed surprise with their depressive symptoms, which included intense sadness, irritability, low energy, sleep disturbances, and in some cases, extreme anxiety especially given their eager and conscientious preparation for baby. When asked, four of the five mothers indicated previous episodes of depression (as teenagers or while in their early twenties); however, none of the women outwardly acknowledged their earlier depression as a risk factor for PPD. The multiparous women were particularly surprised by the onset of depressive symptoms. Jane, a second-time mom and Registered Nurse who had enlisted the support of a midwife for this birth, put it this way: "I think that that is what baffled me the most getting depression this time, when I had everything I wanted. I had everything in place. … We were financially set. … I had such a wonderful birth experience." This sentiment was repeated by all of the second-time mothers: they had believed that by having "everything in order" and "in place," they ought to have been spared the grip of depression. They "waited so long," "planned" for, and "wanted" the baby. Jane added, "I just want to run away from them [her children]. Like I know I love them. …it's really hard for me." … "I don't know what I was expecting, but [it's] just a lot different than I thought it would be."

Greta, the only primipara, had her expectations shattered when she was forced to succumb to a grueling labor, a whirlwind of medical interventions, and baby's eventual arrival by caesarean birth. She described her disappointment with the birth experience and gave a glimpse into her determination to breastfeed her baby:

> Nothing about the birth happened the way we had imagined. … I didn't want to be induced. I didn't want morphine. I ended up with a C-section. It seemed like all that we

> had left was breastfeeding and I really wanted to make it work. … My delivery and my birth went so horrible; it's the one thing that I felt that I could have some control over.

For Greta, breastfeeding became a way of taking back control after the complicated birth—she felt as though breastfeeding was her last hope.

When asked how they prepared for breastfeeding, the four second-time mothers referenced their previous breastfeeding experience and the difficulties they had at that time (from problems of positioning to not feeling supported). They spoke of persevering through the challenges of feeding their first baby, and, having been successful, they now looked forward to breastfeeding this baby.

Three of the mothers said that they had attended prenatal classes offered by the health region. Of these three, only Mary, a second-time mother and Registered Nurse, attended the breastfeeding class. She offered that while she didn't find the classes particularly helpful, she believed they did help her husband understand the importance of breastfeeding. Greta also found the prenatal classes to be most helpful to her husband, but she regretted not attending the breastfeeding class:

> I wish that I would have. … I didn't realize how challenging breastfeeding was going to be. … Like he fought me at the breast before, and then I was thinking that he doesn't like my milk. Like there are so many things that you don't know.

Jessica's infant feeding decision was somewhat different than the other mothers' as she decided prenatally to feed her baby both breast and artificial baby milk (formula). While Jessica spoke of wanting her baby to have "the initial milk" [colostrum], she emphasized that, for her, breastfeeding was burdensome. It is significant to note that Jessica stopped all breastfeeding two months prior to her perceived onset of PPD. At that time, she experienced debilitating anxiety and was tormented by thoughts of harming her children.

In summary, women made their decision to breastfeed early in pregnancy, were hopeful about their ability to breastfeed, and valued their milk as important to their baby's health. The multiparas had breastfed their first baby, and expressed that although breastfeeding had been a challenge, they had decided to try again. Greta did not anticipate breastfeeding difficulties.

Theme Two: Learning the moves and wanting reassurance (establishing the breastfeeding relationship in hospital)

Mothers praised the nursing care they received throughout the birthing process; however, the postpartum experience in hospital was not so highly regarded. Mothers expressed that breastfeeding required learning (and relearning) techniques in order to establish the relationship with baby and none of the mothers believed they had enough practical help or encouragement to breastfeed with confidence. Even the second-time mothers expressed that they longed for reassurance that they were "doing it right," and that their babies were "latched on properly." Both Mary and Patti attributed their feelings of being neglected by nursing staff to their being second-time mothers. They perceived that nurses expected them to know what they were doing when it came to infant care and breastfeeding. They felt dismissed and believed that nurses viewed them as difficult or "ridiculous" if they asked for help. For Greta, the trauma of her labor, caesarean birth, and her perception of an overbearing hospital environment left her frustrated and exhausted:

> I remember them doing the bath like right after I had him. I remember being so tired and thinking, "Why are we doing the stupid bath right now? That really bothered me. I was just thinking, "I just endured over 40 hours of labor. I just [had] surgery. I am exhausted! I slept maybe 45 minutes. I am not even hearing you!"

She had hoped for a calm, quiet experience, but instead she said that she and her husband were made to feel pressured, confused, and overwhelmed. More than once Greta mentioned her desire

to be released from the hospital. Referring to her attempts to establish breastfeeding in hospital, she said:

> It was a bad experience for me. …. I would ask for help, and they would just plunk him on and they wouldn't really walk me through how to do it. I didn't really know what I was doing but I didn't really feel that was helpful for me. …
>
> …they were telling me that I needed to supplement and I didn't want to. Breastfeeding was really important to me. I didn't understand what finger feeding was; no one really explained it to me. I thought that supplementing just meant giving a bottle of formula, and I knew that formula changes a baby's gut and that a bottle could disrupt our breastfeeding relationship. … One nurse made me feel like absolute crap. … She was just basically telling me that I was not doing the right thing for my son, by not supplementing.
>
> …that just kept running through my head until I was like, "Oh my God, what do I do? … I did start to get a little bit of the baby blues. … I did cry. Not a lot. But more at night when I was tired, and he was crying, I would cry.

All four multiparous women also recounted similar "bad" breastfeeding experiences in hospital, whether with this baby or their previous baby. Challenges included having difficulties with latching baby, worrying about baby's weight loss in the first 72 hours, not understanding terms and skills used by nurses associated with supplementing and pumping, and finding nurses' comments unhelpful. For Jane, it was an experience that she was unwilling to endure a second time:

> My [first] experience with breastfeeding was not good. We had a hard time getting him to latch. … They wanted to keep me in longer than the two days because he had lost so much weight and he was jaundiced, and I wanted to get the hell out of there … which was part of the reason why with [this baby] I didn't want to [stay in the hospital]. … With [this baby] I was terrified because I was like, "Oh my gosh, this is going to happen again!" But he was the complete opposite. … We put him on [the breast] when he was five minutes old and he did fine. We had no issues with latching.

Mothers who stayed in hospital after the birth of their babies had the impression that nurses were too busy or were "just going through the motions" to help with breastfeeding. Mothers recalled that nurses were always in a "hurry," "rushed" and "had too much to do." Mothers wanted nurses

to stay with them longer while assessing feeding and for nurses to explain what they were doing instead of merely using a "hands-on" approach. In short, mothers wanted nurses to be more "sensitive" and "receptive" to their needs, and they wanted to have conversations surrounding their babies' well-being, including feeding.

On a positive note, the care provided by certified lactation consultants was praised; however, not all of the mothers who requested to see a lactation consultant were given the opportunity. Mary noted,

> Because I am a nurse and I think that they knew that I was a nurse …, I felt like they would think that I was being ridiculous if I asked again. And they weren't really receptive to me seeing a lactation consultant, and I know what the whole hospital system is like.

For Greta, the time spent with a lactation consultant on her last day in hospital helped to bolster her confidence:

> She was thorough when she was teaching me how to nurse him. … She just kind of talked me through it. And I did everything … so she was in the room but she didn't put the baby on. She walked me through it. She showed me how to change his position. … And she was like, "All you have to do is move his feet." So, she showed me the little things that made such a huge difference to getting him on and for him and me to be comfortable. …She held my hand, just by talking to me.

Overall, the hospital environment was portrayed as unfavorable to establishing the breastfeeding relationship. Mothers gave the impression that their care lacked continuity and that they felt uncomfortable, vulnerable, and anxious in hospital.

Theme Three: Breastfeeding in the dark (maintaining the breastfeeding relationship while trying to manage the symptoms of depression)

Once discharged from hospital, and in the comfort of their homes, the mothers spoke fondly of breastfeeding their babies; at the same time, challenges associated with breastfeeding were often perceived as overwhelming. All expressed feelings of frustration because symptoms of depression left them feeling emotionally out of control. Challenges surrounding infant feeding

with depression included worrying about milk supply, feeling that pumping was overwhelming, worrying about whether to introduce a soother and/or bottle, baby not taking a soother/or bottle, feeling that baby must be eating solid foods by six months, feeling pressure to wean baby before returning to work, and letting others help with feeding baby (particularly if mothers didn't feel listened to). The symptoms of depression that exacerbated these challenges included sleep disturbances, extreme fatigue, and uncontrollable anxiety. Complicating matters was an underlying sentiment among mothers that one must "breastfeed the right way," "properly," and "by the book." Mary described the first time she and her husband "practiced" giving their baby her milk from a bottle. We can hear the intensity with which she held onto her breastfeeding relationship with baby despite her feelings of anxiety and uncontrollable emotions:

> I was really uncomfortable with giving the bottle … because I didn't want to give up that thing that we had. … But I knew at that point that I was depressed and that the anxiety I was feeling was more hormonal. … So, I left the house and left a bottle with my husband. … because I heard that they can even smell you; that it can be distracting and they won't take the bottle. He told me that she took the whole thing and really didn't put up a fuss. I drove home so fast; I was crying the whole drive home. I walked in the door and I was like, "Just give her to me!" I sat down and breastfed her right after she had this bottle. And he was like, "What's the matter?" And I said, "She doesn't need me anymore and now anybody can do my job. She doesn't even need me!"

Jane also alluded to breastfeeding the "proper" way as she discussed stressors such as the pressure to start introducing solid foods at six months. Prenatally, she had planned to exclusively breastfeed her second baby to six months, at which point she would introduce solid foods, and to continue to breastfeed until she needed to return to work:

> We breastfed [our first baby] until he was about six months. … And then as soon as I stopped [breastfeeding] I regretted it. …. It really bothered me that I stopped. I wished that I would have kept going but I didn't. So, with [this baby] I swore that I wasn't going to pump and that I would breastfeed him until he was at least one year.

Overwhelmed with depression, the breastfeeding relationship envisioned prenatally left Jane feeling besieged as her baby had refused solid foods at six months and would accept nothing but mother's milk. She found it too strenuous:

> I felt resentful that I had to nurse him. … I didn't even want him anymore. I think that a lot of it was that he wasn't taking solids. He wasn't doing that natural weaning process that they talk about. … I'm still nursing him eight times [a day]. … He only wants me when he is hungry and tired.

Patti was the one mother who had endured depression throughout both of her pregnancies. She had been on antidepressant therapy since she was a teenager and was treated throughout this pregnancy. Her first baby was born prematurely and was fed both breastmilk and artificial baby milk because he "needed more calories." Patti added that breastfeeding with depression with her first baby meant having the opportunity to bond:

> It was like the only time I held her. I really did feel that was the only time I got to bond with her and the rest of the time was just like … here's this kid … she doesn't give a shit about me anymore. Like I would set her down and she wouldn't even care. So, I just felt like … needed.

However, Patti explained that, now that she was caring for two children while trying to manage the symptoms of depression, the demands were too big to enjoy exclusive breastfeeding. Discouraged by baby's need to eat every three hours, she describes how she dealt with the challenges of sleep deprivation and feeding by:

> … giving her formula now … like she had a bit of [formula] at night and I thought that it would help her sleep better. … And they say that formula takes longer to digest … so maybe she can sleep a bit longer, maybe I can get a few more hours of sleep. … I'm getting resentful towards this kid because I feel that this is all that I do, is just feed her all of the time.

Greta expressed that breastfeeding made her feel better, referring to challenges with breastfeeding as "bumps in the road" and believing that stopping breastfeeding would make her feel worse:

> I am still breastfeeding. I pushed through. … I think that it made me feel better because it was the one thing that I was successful at, as a mom, because my birth went so shitty and everything just kind of spiraled down and my mood and everything.

All of the mothers referred to breastfeeding as important to creating a close "bond" with their baby. One summed up the "breastfeeding relationship" as follows: "The way they reach up and touch your face while you are feeding them. … It is just a nice thing that you have with the baby." Even Jessica, the mother who had prenatally decided to feed her baby breastmilk and artificial baby milk, commented: "You love it [breastfeeding] … but I liked the bond when I was rested and when he wasn't crying."

The experience of breastfeeding with PPD manifested itself as a significant source of connection between mother and baby, as a semblance of control while dealing with the tumultuous nature of anxiety, and as a source of frustration when babies' need to eat conflicted with mothers' need to take time for themselves.

Theme Four: Breastfeeding under wraps and waiting it out (seeking support)

The experience of breastfeeding with PPD manifested itself as a time of seclusion and a period of waiting until the challenges pass. Mothers did not feel comfortable breastfeeding their babies in public, or even in front of extended family members. At the same time, they kept their feelings of depression "hidden" from loved ones, and for most, the process of seeking help for depression was delayed.

Despite frequent reference to the connection that breastfeeding seemed to confer between mother and baby, most mothers also discussed feelings of isolation in their roles as the "primary caregiver." Mothers commented that while they had received significant support from their spouses throughout the pregnancy and early postpartum, they needed ongoing support to breastfeed, particularly when they were feeling deprived of sleep. For example, they appreciated

when husbands woke up in the night to help with diaper changing or soothing, but they were disappointed if this kind of help wasn't offered without asking for it (and they rarely asked for it). Mothers also expressed that they appreciated when families (their own mothers in particular) helped in the early postpartum weeks with meal preparation and household chores. Again, that kind of support didn't last for all of the women.

When extended family was involved with care taking, both Jane and Mary, in particular, did not feel listened to. Mary offered that if her baby needed to be fed in her absence, she felt better about leaving the baby with a babysitter than with grandparents, because at least she knew the babysitter would "do what I told her to." Jane also found it difficult to let relatives help with feeding. Jane recalled that the first time she left her baby with grandparents, the baby refused her pumped milk from a bottle. When Jane called home to see how things were going, she found out that baby had not eaten for several hours. She flew home in a flurry of tears, anger, and frustration with the grandparents for not having called her sooner. At the time of her interview, Jane's baby was nine months old and she spoke of feeling trapped in her home: "I just want to get out of the house, leave the boys behind…but I can't because I have to feed this kid!" When asked if she breastfed in public, Jane replied:

> I don't think society supports that. When he was about three weeks old, he was crying in the doctor's office, so I fed him. Like, I even had him covered, and a guy beside me said, "Must you?" And it was just like, are you kidding me?! Yes, I must. … So you are in this fight between I want to do the best I can … but at the same time I don't have the support that I need.

Not feeling comfortable to breastfeed in public spaces or even in front of family was a negative sentiment shared by all of the mothers.

Mothers generally found it difficult to ask for help and most were reluctant to share that they were struggling with depression with anyone. When she did reach out to family, Patti

referred to her depression as being "poo-pooed." Jessica told about how her mother reacted to her feelings of anxiety:

> [Mom] was mad at me. … She was like, "Why are you so stressed out? Why are you acting like this? You live this comfortable life; [your husband] works his butt off to give you everything that you want. … Just shake it off! What the hell? You're scaring me. Quit talking stupid!" And she was getting mad at me because she didn't understand because she has never gone through it. And I was feeling even worse and like freaked out.

Mothers believed that they should be able to handle their predicament on their own. Greta commented:

> I was feeling like really sad and just really isolated and really stuck! Like, "This is my life, Oh my God!" … And I have a really hard time reaching out, I guess. … I wasn't really expecting support. … I wanted to be able to … handle it on my own. I didn't want to have to deal with depression and I worried about him [the baby] and how it affected him, and that sort of thing. I just thought … "How am I going to take care of this baby? And I am feeling so crappy!" I found it to be really hard just to reach out and admit that I was feeling the way that I was. I don't know why I was so worried about being stigmatized, but I was. I just didn't want that label of being a person with postpartum depression. Like, there were people that I was working with and other people that have babies and they all seem so fine and they pull it together. And I was like, "Why can't I?"

For most of the women, it took weeks beyond the initial symptoms of PPD before they sought professional support. Greta captured the sentiment of all of the mothers regarding the support they received from the postpartum depression group:

> That group, I'll tell you, that group is a real lifesaver. It gets me through the weeks, knowing that I have that support! That I can just kind of share what I am going through. Just hearing other people's stories too. Like, maybe they aren't the same as your own, but at least you know, in the middle of night when you are having a bad day or are crying, whatever is going on in that moment, you know that you aren't the only one. … So that group has been huge for me.

DISCUSSION

As Table 1 shows, the women shared demographic characteristics positively associated with breastfeeding, for example, being between the ages of 24-33 years of age, being married,

having post-secondary education, and being of an average socioeconomic status (Thulier, & Mercer, 2009). Participants also identified psychological and social aspects identified with breastfeeding such as having the prenatal intention to breastfeed, and having support from husbands/partners to breastfeed (Thulier, & Mercer, 2009; Meedya, Fahy, & Kable, 2010). Two of the five mothers were attended by midwives, which may have bolstered their breastfeeding intentions and support in general.

Our findings highlight the notion that childbearing women are emotionally vulnerable (Fooladi, 2004; Kendall-Tackett, 2007; Zauderer, 2009) to the physical and psychological stress associated with postpartum adaptation and transition. Life with a new baby can be challenging to say the least. Thus it may come as no surprise that for the mothers interviewed in this study, the lived experience of breastfeeding with PPD was expressed not unlike that reported in the literature for mothers without PPD (McInnes and Chambers, 2008; Mantha, Davies, Moyer, & Crowe, 2008). The results resonate with those of larger qualitative and synthesis studies with regard to the breastfeeding experience in general and the critical need for improved support interventions (Hannula, 2008; Kanotra et al., 2007; Schmeid, Beake, Sheehan, McCourt, & Dykes, 2010). Given that all mothers in this study had experienced either depressive symptoms or anxiety before the onset of PPD and were thus at a significantly increased risk of PPD, heightened awareness with regard to perinatal screening for depression among health care professionals is recommended (Robertson, Grace, Wallington, & Stewart, 2004). Further, because mothers did not perceive themselves to be vulnerable to PPD, increased education for women and families about the risk factors for PPD is suggested (Robertson et al., 2004) as is anticipatory guidance about the symptoms of depression, which may help to offset the stigma associated with PPD (McCarter-Spalding & Horowitz, 2007) and women's high expectations.

As far back as 1958, Niles Newton postulated that oxytocin, the hormone responsible for the let-down reflex in breastfeeding, may help mothers feel relaxed and less anxious, and that it may contribute to maternal-infant attachment. Endocrine and behavioral adaptations caused by the release of oxytocin during breastfeeding mediate the stress response in mothers and promote sedation (Groër & Davis, 2006). Additionally, evidence now suggests that when breastfeeding goes well, it may protect maternal mental health, (Dennis & McQueen, 2009; Donaldson-Myles, 2011) not only by attenuating stress, but also by modulating inflammatory responses common in the last trimester of pregnancy through to postpartum (Kendall-Tackett, 2007). This theory is based on emerging research in the field of psychoneuroimmunology, which has revealed that inflammation is involved in the pathogenesis of depression by increasing levels of proinflammatory cytokines (Kendall-Tackett, 2007).

Four of the five mothers continued to breastfeed despite their depressive symptoms and expressed emotional benefit as conferred by the breastfeeding experience. This is consistent with a larger descriptive study exploring infant feeding patterns in women with PPD, which concluded that it is important to consider mothers' breastfeeding intentions in conjunction with PPD treatment, as well as to assist in the management of breastfeeding difficulties (McCarter-Spaulding & Horowitz, 2007).

In this study, mothers described breastfeeding difficulties from the establishment of breastfeeding through to the time of interviews. A major theme for all of the women was anxiety and self-doubt, and a perceived lack of support for breastfeeding from nurses in the hospital. Those who asked nurses for help felt confused by the variety of suggestions given to establish breastfeeding, and they wanted more time with lactation consultants. These patterns in the mothers' stories correlate to the metasynthesis by McInnes and Chambers (2009). The authors

refer to “the importance of skilled help,” “pressures of time,” “the medicalization of breastfeeding,” and “the ward as public place” as challenges inherent to supporting the breastfeeding mother and baby. Schmeid, Beake, Sheehan, McCourt, and Dykes (2011) propose that the organizational structure of hospitals with staff shortages and a multiplication of tasks leave both nurses and mothers feeling pressured for time and that well-intended interventions may disempower women and undermine breastfeeding intentions. Our findings suggest that positive breastfeeding experiences in hospital, particularly for those mothers predisposed to depression, requires not only that nurses are proficient to provide practical breastfeeding education, but also that nurses have and take the time to provide constant encouragement and reassurance, which these mothers felt they lacked.

Breastfeeding difficulties, as identified by the mothers in this study were also exacerbated by the deleterious symptoms of PPD: from not having help with nighttime feedings, to the general perception that breastfeeding in public is not well received by others. Most recent research suggests that advising women to supplement or wean decreases total sleep time, and increases the risk of depression (Kendall-Tackett, Cong, & Hale, 2011); however, an important caveat is that breastfeeding difficulties may increase the risk of depression, and as such, appropriate and timely interventions are critical (Kendall-Tackett, 2007; Watkins et al., 2011). Confirming the seminal work by Beck (1992), which found that women with PPD were “besieged with insecurities” (p. 170), analysis of the data in this study revealed that mothers may have benefitted from extended postnatal support, both for the natural challenges associated with breastfeeding and for their depressive symptomology.

LIMITATIONS

The findings of this study should be considered from a perspective of hermeneutic phenomenology: the methodology and context of this study necessarily influence the results. It is acknowledged that transferability of the findings is further limited by purposive sampling, which yielded a small, homogeneous group of women: all were English speaking, well educated, of a moderate socioeconomic status, between the ages of 24 and 33, and in committed relationships. Also of interest was that all of the mothers interviewed were educated in healthcare, or working in a healthcare setting, which may have influenced both their knowledge about and the outcome of their infant feeding experience with PPD. All women were at similar points in the progression of PPD at the time of the interviews, all were receiving treatment, and all reported improvement in their moods.

IMPLICATIONS FOR NURSING

Nurses need to enhance their role as breastfeeding and depression educators across an extended perinatal period. Continuing to work alongside other health care providers (midwives, physicians, etc.) to assess the effectiveness and appropriateness of prenatal classes may be an important first step to ensure that mothers and support persons are receiving adequate and consistent information regarding both PPD and common breastfeeding challenges.

The issue of nursing support for breastfeeding should be explored from a sociopolitical perspective. Such an approach may help to determine if nurses have the cultural and institutional support they need to provide appropriate care to mothers and babies. Further, it is recommended that nurses should approach women at risk for PPD and their families in a participatory manner so that responsive interventions result as mothers work through natural challenges associated with establishing

the breastfeeding relationship in hospital and maintaining the breastfeeding relationship in the community. The implications are summarized in Table 2.

INSERT TABLE 2 ABOUT HERE

CONCLUSION

This study used a purposive sample of five women to explore and interpret the lived experience of breastfeeding among mothers with PPD. The mothers who were interviewed made the decision to breastfeed; however, this is not meant to imply that mothers do not have the right to be supported if they choose not to breastfeed.

The mothers valued the breastfeeding relationship when it went well; however, breastfeeding difficulties intensified symptoms of depression. Women who are at risk for postpartum depression, and who choose to breastfeed their infants need increased anticipatory guidance to be prepared for the demands of motherhood, ongoing support from health care professionals and loved ones to continue to breastfeed when faced with the debilitating symptoms of postpartum depression, and appropriate treatment throughout the perinatal period and beyond.

The benefits of breastfeeding to babies, mothers, and society are well established, as are the deleterious effects of maternal depression. The results of this study warrant further research on the administrative and procedural demands Registered Nurses face. Additionally, a new approach to breastfeeding support interventions, particularly for mothers at risk for depression, is needed. We must continue to encourage all dimensions of support that focus on breastfeeding relationships including mother–baby, mother–baby–nurse, and an increased involvement of those who support mothers.

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Table 1: Descriptive Characteristics of the Mothers

Characteristics	**N (5)**
Age (mean years)	28.2 (range 24–33)
Time postpartum (mean months)	6.7 (range 4–10)
PPD onset (mean weeks)	7.6
Ethnic Background	
Caucasian	3
Cree	1
Métis	1
Post-secondary education	5
Household income (CAD) > $55,000	5
Marital status	
Married	4
Living with partner	1
Multiparous	4
Primiparous	1
Birth	
Vaginal	3
Vaginal after Cesarean birth	1
Cesarean birth	1
Birth Attendant	
Physician	3
Midwife	2

Table 2: Suggestions for Nursing Practice

Theme	Suggestions	Rationale
1. Making the decision to breastfeed and great expectations	Evaluate prenatal classes and/or offer parenting classes to increase emphasis on natural breastfeeding difficulties and postpartum care for newborns and mothers.	To bring to awareness to parent's "great expectations" versus realities of life with a newborn. Prenatal mothers felt ready, but even multiparous mothers experienced breastfeeding challenges postpartum. Mothers' intention to breastfeed is the single most important factor impacting breastfeeding initiation and duration (Riordan, & Wambach, 2010). Because breastfeeding difficulties impact breastfeeding success (Watkins et al., 2011; Zauderer & Galea, 2009), anticipatory guidance as offered through prenatal teaching may help to normalize breastfeeding challenges and increase self-efficacy in mothers prone to depression (McCarter-Spaulding & Horowitz, 2007). Anticipatory guidance may also help to prepare mothers for the stress, anxiety, and fatigue that often accompany motherhood (Meedya, Fahy, & Kable, 2010).
2. Learning the moves and wanting reassurance (Initiating the breastfeeding relationship in hospital)	Reevaluate hospital routines, policies, and visiting times and modify those in conflict with research evidence. Review nurse workload and duties.	Mothers felt anxious and frustrated in hospital and wanted nurses to spend more time listening to their learning/support needs. Hospital environments were described as rushed and mothers felt neglected: not lending to the "taking in/taking hold" phases of maternal attachment (Rubin, 1961), or to creating an environment conducive to learning.
	Encourage use of the Baby Friendly Initiative™ as a model of care and support mandatory breastfeeding certification for all frontline staff.	Mothers felt confused by conflicting information. Evidenced based care models help to build a trusting relationship between parents and care providers because knowledge and skills are consistent and research based (Baby Friendly Initiative, 2011).
	Continue to teach parents and hospital staff about the importance of early skin-to-skin contact.	Mothers expressed that they loved bonding through skin-to-skin contact with their baby. Skin-to skin promotes breastfeeding initiation when the breast is supple, and baby is alert. It may encourage maternal

Theme	Suggestions	Rationale
		attachment even if mothers do not breastfeed (Baby Friendly Initiative, 2011).
	Support human milk banking.	The preferred nutrition for baby is mother's milk. When this is limited, pasteurized human donor breast milk is recommended (Kim, & Unger, 2010). Access to human milk may reduce feelings of guilt for mothers who understand the risks associated with artificial baby milk but who initially struggle to produce milk (Jones, 2003).
3. Breastfeeding in the dark (Maintaining the breastfeeding relationship while dealing with symptoms of depression)	Focus efforts on maternal depression education for health care professionals.	When symptoms of depression are detected too late or not at all, mothers are prevented from seeking timely and appropriate treatment. There are safe medications and other treatment options for mothers that preserve the breastfeeding relationship and improve postnatal mood (Kendall-Tackett et al., 2007).
	Encourage education and involvement of other close family members in parenting teaching.	Mothers expressed that they needed more support from family members. They wanted to be listened to and respected as opposed to advised. Appropriate involvement of loved ones may help to offset maternal stress and fatigue.
4.Breastfeeding under wraps and waiting it out (seeking support)	Teach public about the importance of breastfeeding anytime and anywhere as a human right.	Mothers reported that they did not feel comfortable to breastfeed in public. This negative feedback may have magnified anxiety, decreased self-confidence, and increased feelings of isolation. By reducing social isolation for depressed mothers, we may help to reinforce her identity and coping mechanisms (Riordan, & Wambach, 2010).
	Continue to teach families regarding community resources such as depression and breastfeeding supports.	Mothers waited extended periods of time before reaching out for supports. They described worry about being stigmatized.

IMPLICATIONS AND CONCLUSION

My personal experience of breastfeeding, and my subsequent work as a maternal child nurse, sparked the idea of exploring the experience of breastfeeding in mothers with postpartum depression. Hermeneutic phenomenology, situated in the realm of human science research, and well aligned to my own philosophic orientation, was used as method. Hermeneutic phenomenology was an ideal approach to the proposed study because of its exploratory nature and the fact that there is limited qualitative research regarding the relationship between postpartum depression and breastfeeding. The five mothers in this study reflected on their experience of breastfeeding with postpartum depression: the four existentials, as suggested constitute the fundamental structure of the human *lifeworld* (van Manen, 1990), were used to jumpstart the initial analysis of lived-experience material. The existentials of lived time (temporality), lived space (spatiality), lived body (corporeality), and lived human relation (relationality) brought focus to the five mothers' experiences and enabled reflection that respected both the unique and the common elements in their stories.

Van Manen (1990) depicts lived time as a subjective experience: our "temporal way of being in the world" (p. 104). The lived experience of breastfeeding with postpartum depression presented itself across all interviews as a time journey from the prenatal decision to breastfeed to the postnatal infant feeding circumstance as described by each mother at the time of their interview.

Lived space is described as "felt space" (van Manen, 1990, p. 102). It is the effect that space has on how we feel. Lived space was used to group statements referring to the experience of breastfeeding in hospital, at home, and in public places. It was evident from the mothers' depictions that the hospital system let them down. Reflecting on my own practice, I understand

how this can happen: often there is little time to assess how a new mother is adapting to her mothering role, and mothers' intentions to breastfeed are sometimes undermined. At home, mothers needed more help to manage the demands of life with a new baby. None of these five mothers practiced breastfeeding in public spaces, which raises questions of whether breastfeeding is the cultural norm, and what are we doing to enable women to feel comfortable feeding their babies in public spaces?

Lived body refers to the fact that we are always "bodily in the world" (van Manen, 1990, p. 103). Lived-body statements were used in this study to group statements specific to the breastfeeding relationship as a physical and emotional bond between mother and baby. Breastfeeding with postpartum depression also manifested as a bodily experience in the form of sleep deprivation.

Van Manen's (1990) lived relation refers to the human experience of *others*. Lived-relation statements reflected mothers' perception of support for breastfeeding, be it by healthcare professionals—nurses, midwives, physicians, lactation consultants—family, friends, or peer support as found in the postpartum depression support program. Again, while breastfeeding was portrayed as important to the relationship between mother and baby, mothers articulated that they needed more support from others for breastfeeding while managing the symptoms of depression. Reflecting on this finding, the suggestion was put forward that ongoing education for families and healthcare professionals be expanded and that prenatal classes be modified to increase both awareness and the coping skills required to manage both the challenges of breastfeeding and maternal depression.

After this preliminary grouping of data, the mothers' reflections were further analyzed and four themes were derived in an attempt to capture the essence of the experience for these mothers and to elucidate the concept of breastfeeding support.

Implications for Practice

The results of this research have the potential to inform healthcare professionals who work with mothers and infants within the context of their families. Specific suggestions for practice have been outlined in the journal portion of this thesis, but perhaps the most significant implication comes from the philosophic underpinnings of hermeneutic phenomenology itself. Hermeneutic, or interpretive phenomenology asks: what is the meaning of being human in this experience? Understanding is sought through interpretation and a dialectic process between researcher and participant. The implication for practice (the challenge for the nurse) is to apply this perspective on the frontline: the nurse becomes akin to qualitative researcher, constantly engaging in dialogue with individuals to search for meaning and understanding in the pursuit of wellbeing. Thus, a simple "Tell me about your breastfeeding experience," can be a first step toward providing responsive care. One might even reflect upon and use van Manen's existentials to inspire the dialogue. For example, the nurse might ask, "What can I do for you right now [time]? What can I do to help you here [space], given your situation [body/past and present experiences] and your supports [human relation]? What are your breastfeeding goals and how can I help you to achieve them?"

Implications for Research

Despite a plethora of quantitative studies to attest to the proven benefits of breastfeeding for both babies and their mothers, many women struggle with breastfeeding and do not breastfeed their babies to the recommended six months. With estimates for postpartum

depression has high as 20% (Canadian Mental Health Association, 2012), and the knowledge that maternal depression has the potential to adversely affect the breastfeeding relationship (Dennis & McQueen, 2009), appropriate support for mothers who have made the decision to breastfeed their infants is a clinical imperative. Yet, attempts to fill the qualitative void, exploring women's satisfaction with support interventions for breastfeeding, have not made headway. Case in point: large-scale surveys such as the Canadian Community Health Survey have failed to capture women's multifaceted perceptions of support due to their limited designs (Chalmers, et al., 2009).

The current study gives insight into the phenomenon of breastfeeding support within the context of depression, which to date has eluded the dominant philosophical orientations that currently guide nursing care of the new mother. For this thesis research, the open-ended and dynamic nature of hermeneutic phenomenology guided the inquiry as the nurse–client relationship took the fore: conversation-style interviews allowed participants to tell their stories in a comfortable environment without interruption. It is recommended that future studies replicate the methods herein as we seek continued understanding of the meaning of support for breastfeeding as it is lived by mothers, particularly those at risk for depression or other vulnerabilities. It is also recommended that a larger sample size of women be used and that a more heterogeneous sample of women be explored. For example, women from a variety of ethnicities, ages, and socio-economic backgrounds should be considered.

Additionally, it is recommended that future research into breastfeeding support investigate the larger socio-cultural contexts of the concept including political, economic, and biomedical contexts. This refers not only to cultural taboos and societal beliefs about breastfeeding but also to the organizational culture of the maternity care system, which

influences the attitudes and actions of healthcare professionals. For example, we need to start asking larger organizational questions. What is the impact of a hospital system that leaves little time for anything but tasks and paperwork? Do nurses have time to facilitate dialogue with mothers that is meaningful, sensitive, and responsive to each unique situation? Do nurses support all mothers equally, regardless of race, socioeconomic status, and ethnicity? What is the impact of all of the aforementioned factors on the long-term health of our children, indeed, on the health of all people? To ask such questions will be to begin to appreciate the complexity of nursing support to breastfeeding, to begin to elucidate the concept beyond its current practical meanings, and to begin the dialogue needed to challenge the status quo.

Knowledge Translation and Exchange

Knowledge translation activities begun at the outset of this thesis research such as connecting with relevant stakeholders—namely the management and staff of the Healthy & Home Program and its affiliate, the Postpartum Depression Support Program—were necessary to gain entry into the study population. The results of the research have already been presented orally and as posters at the 20th Annual Western Perinatal Research Meeting in Banff, AB, in February 2012; at the Life Sciences Conference at the University of Saskatchewan, Saskatoon, SK, in March 2012; and at the Saskatchewan Lactation Consultants Association in April 2012. Inservices will inform the staff of the Royal University Hospital Postpartum Unit and other community stakeholders including the Healthy & Home Program, Healthy Mother Healthy Baby, and the Baby Friendly Initiative Coalition.

Conclusion

The exploratory nature of this thesis project has proven to be both challenging and rewarding. Certainly the research experience, from delving into the complexities of hermeneutic phenomenology, to the interviews with the mothers, to the presentation of results to colleagues has helped me to expand the boundaries of my own practice. It is hoped that this initial insight into the complex phenomenon of the breastfeeding experience in mothers with postpartum depression will be a first step toward providing enhanced support for these women.